H.R. 4833, A BILL TO AUTHORIZE THE VA TO PROVIDE COMPREHENSIVE TREATMENT SERVICES TO VETERANS SUFFERING FROM POST-TRAUMATIC-STRESS DISORDER, AND THE VETERANS' READJUSTMENT COUNSELING PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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H.R. 4833, A BILL TO AUTHORIZE THE VA TO PROVIDE COMPREHENSIVE TREATMENT SERVICES TO VETERANS SUFFERING FROM POST-TRAUMATIC-STRESS DISORDER, AND THE VETERANS' READJUSTMENT COUNSELING PROGRAM

THURSDAY, MARCH 29, 1984

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, DC.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Mica, Evans, Penny, Staggers, Rowland, Slattery, Daschle, Bilirakis, and Johnson.

Also present: Hon. Don Edwards, ranking member, House Veterans' Affairs Committee.

Mr. Edgar. Good morning.

Before we begin this morning, let me announce that the Republicans have a Republican conference this morning where they are being briefed by Secretary Shultz on foreign policy. They have sent their regrets but have urged us to proceed.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. Edgar. This is our second legislative hearing on matters affecting the VA's Department of Medicine and Surgery. We expect to hear testimony on H.R. 4833, a bill to authorize the VA to provide comprehensive treatment services to veterans suffering from post-traumatic-stress disorder.

During a series of oversight field hearings last year, we were able to visit special treatment units known as combat units in which Vietnam veterans suffering from PTSD can receive special attention and treatment. We toured combat units which were established at local initiative in operation at Bay Pines, FL, North Chicago, IL, and at Menlo Park, CA, which is part of the Palo Alto VA Medical Center.

Incidentally, an award-winning documentary on the program at Menlo Park has been shown twice this week on the House Broadcasting System, Channel 6. I believe it is scheduled to be shown again tomorrow at 11 a.m. for the last time. I commend this program to my colleagues. It is a very moving portrayal of the struggle of a number of Vietnam veterans, some of them highly decorated for valor in the face of the enemy, to deal with their own reaction to their experience in Vietnam.

I want to thank Fred Gusman, the director of the Menlo Park combat unit, for making this film available to the Congress. I don't want to focus this hearing exclusively on the men shown in that documentary, but if there is anybody here who doubts the real effects of PTSD, I strongly urge them to view this film.

One of the questions we hope to address today is the role that we can play in improving existing combat units and encouraging the establishment of other units where there appears to be a need. I understand that these units were developed autonomously and that a lot of informal networking and sharing of experiences takes place.

I introduced H.R. 4833 as a vehicle for formalizing and expanding these units, establishing a means of educating more health care professionals about the diagnosis and treatment of PTSD, and to ensure that the program can compete fairly for money and personnel needed to treat veterans suffering from PTSD. I want to emphasize that it is not the intention of Congress to dictate to the VA how to treat veterans for PTSD. We want to encourage a program we have seen firsthand which many of us think is very effective. We want to be certain there are sufficient resources available so that where there is a need for additional treatment programs, the VA won't have to curtail services for other veterans. At the same time, we want to make sure that the whole person is treated and that there are no obstacles in rehabilitating these individuals.

I think it is fair to say that part of our inspiration for this legislation is the very successful Geriatric Research, Education and Clinical Centers Program, the GRECCS Program, for geriatric care, which was first authorized in the 96th Congress.

What we envision in H.R. 4833 are centers of excellence where outstanding clinicians can participate in research and educational efforts to help ensure that PTSD is accurately diagnosed and correctly and promptly treated. I want to make it clear that this legislation is not intended in any way to make these units the sole source of treatment for veterans suffering from PTSD. It is our intent to encourage these units to become models and for them to share their knowledge with any health care professionals involved in the treatment of PTSD.

We are also going to receive testimony this morning on the VA's Readjustment Counseling Program. This program has reached maturity in the past 2 years. At the same time, it has not lost any of the dynamism or spirit of dedication which has made the program so successful. It was just a little more than a year ago that we held a hearing on extending the Readjustment Counseling Program. I am sure everyone here knows that Public Law 98-160 extended this program for an additional 4 years. Originally, we were only going to extend it for 1 or 2 years. However, we beca[illegible] convinced of the very valuable service being provided by the [illegible] and extended it for 4 years.

During our consideration of the VA's fiscal year 1985 budget request, we questioned why the VA wasn't trying to expand this program in view of the large numbers of people using the programs, numbers much greater than the VA had projected. We were told that the VA did not have adequate personnel authorization, FTEE, to utilize the contract funds to enhance or expand the Vet Center Program. I made a recommendation, which the full Committee accepted, to make these funds available in fiscal year 1985 for 220 FTEE to expand the VA's in-house capacity to provide readjustment counseling. We are going to work very hard to ensure that the Appropriations Committee goes along with this recommendation.

Incidentally, the Senate Veterans' Affairs Committee has made an identical recommendation, so we will be adding $7.2 million and 220 FTEE to the VA's budget request for this program if the Appropriations Committee agrees with our recommendation.

It is our intention that the VA use these resources to augment staff at centers where the demand for services exceeds the capability to provide it, and also to open new centers where populations are not being served by existing centers. I want to emphasize that the need for flexibility in expanding this program is very important. If there is a need for services 2 days a week at a particular location, the VA should not ignore that need. This is a sizable expansion we are considering, which I hope will enable the VA to meet most of the need.

Rather than recite the history of the Readjustment Counseling Program, I think I will stop at this point and go to our witnesses.

I would like to ask unanimous consent for the submission of remarks from our colleague, John Paul Hammerschmidt, who has some opening remarks. Without objection, they will be made a part of the record.

[The statement of Mr. Hammerschmidt follows:]

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Thank you, Mr. Chairman.

You have outlined the purpose of our hearing today and I agree with your statements.

In our travels last year to VA medical centers we observed thousands of dedicated people giving excellent medical care to our veterans. We also observed several of the "combat units" which you have described. We were impressed with what we saw. We noted what appeared to be some excellent modalities of treatment for Vietnam veterans with post-traumatic-stress syndrome. We reached a conclusion that legislative recognition of these units might well be sought and that a structural mechanism for them with VA's Department of Medicine and Surgery would be desirable. We also concluded that a modest budgeted expansion would be appropriate. It was for these reasons that you, Mr. Chairman, developed the legislative proposal before us.

Mr. Chairman, this kind of treatment modality is still relatively new. It obviously works for a significant number of Vietnam veterans. Hopefully, it will work for others. I would hope that our witnesses this morning will agree, and by their testimony, assist us in refining this good legislative idea to the end that our committee may act upon it and guide it through the Congress.

Mr. Chairman, a few weeks ago press stories indicated that VA may have misspent or otherwise misused substantial sums of money which had been appropriated for contract counseling in the Vietnam Veterans Readjustment Counseling Program. These stories resulted from a hearing before another subcommittee in the Congress. It matters little that the stories gave an incorrect impression. It matters little that the other subcommittee was in error or misinformed on several aspects of the issue. What does matter is that the record be made precise, that incorrect conclusions be corrected, and that the air be cleared.

Mr. Chairman, it is true that money appropriated for contract counseling was used by VA for other purposes. But is it also true that they were good and fully justified purposes. Further, it needs to be noted that this committee and our Senate counterpart as well as both Appropriations Committees of the Congress were kept informed about the matter and offered no objections. Finally, it needs to be stated that VA has had some difficulties with the contract program. I think it commendable that it has moved cautiously in this area, that it has tried to use contracts only when actually needed, and that it continues to review all aspects of this situation to the end that its money is spent wisely and usefully.

Mr. Chairman, I don't want to belabor this matter, but I would certainly hope and expect that the VA witnesses would at least touch on this subject during their appearance before us today.

One final thought, Mr. Chairman—I endorse the proposal to use surplus contract money to enhance and expand the Readjustment Counseling Program, including the increase in personnel, and I was pleased to join with you and Chairman Montgomery in urging the Appropriations Committee to support us on this vital issue.

Thank you, Mr. Chairman.

Are there any other opening statements? I see my colleague, Mike Bilirakis from Florida, has joined us.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. **Bilirakis**. I have an opening statement, Mr. Chairman.

I join you, sir, in welcoming our distinguished speakers here this morning, and I look forward to their testimony. The whole subject of readjustment counseling for our Vietnam veterans, as well as for veterans of other wars, is one, as you say, which deserves the closest attention of this subcommittee. I know how important these programs are to the veterans who have been helped by them, and I am convinced that they are important to the Nation as a whole because we all lose, we all lose, when an individual is unable to take his proper place in society and to share with others the special skills and ideas which are within each of us.

Last year, as you recall, sir, this subcommittee traveled to my area of Florida and we visited two places where Vietnam-era veterans could go for friendship and counseling, with which we were all very much impressed. The Outreach Counseling Center in St. Petersburg is a meeting place for men who shared a common experience in Vietnam, as Vietnam veterans returning home to a country unsure of itself and its soldiers. We heard from many who are leading happier and more productive lives today as a result of the support and counseling they received there.

We also visited, if you will recall, sir, the combat unit at the Bay Pines Hospital and were deeply moved by the stories of the deeply troubled veterans in that program. We were equally impressed with the great efforts they were making to benefit from professional care and counseling so that they could return to families and friends and jobs with a better understanding of themselves and of others. It was a great opportunity to see firsthand the need for treatment programs for veterans suffering from post-traumatic-stress disorder, and it was inspiring to learn that Bay Pines, like other hospitals throughout the VA system, had established this program independently and at their own expense in response to that need. So I am very anxious, along with you and the other members of our subcommittee, to hear what our witnesses have to say about these two important Readjustment Counseling Programs and I look forward to their presentations.

Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you very much.

I would like to turn now to my colleague, Don Edwards, from California, who has been instrumental over the years in focusing attention not only on Vietnam era needs but the needs of veterans of all wars. He particularly has been helpful in looking at some of the more controversial issues that we face before this committee. I want to thank him for his leadership in that area, and also recognize him as the ranking member of the House Veterans' Affairs Committee.

Don, thank you for coming this morning.

OPENING STATEMENT OF HON. DON EDWARDS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND RANKING MEMBER, HOUSE VETERANS' AFFAIRS COMMITTEE

Mr. **Edwards**. Thank you very much, Mr. Chairman. I appreciate your allowing me to come today. This is the hardest working and most efficient subcommittee in the Congress and I compliment all of you on the fine work you do. It is just splendid. I especially commend you on these particular hearings because this is very important oversight work you are doing.

As you remember, Mr. Chairman, you and I and Senator Cranston years ago fought the battle for these outreach centers, and they are working out very, very well. Certainly, in California, they are just outstanding. It just makes good sense—and I won't repeat what you said in your opening statement—but it makes good sense that these centers be expanded and new ones be added to areas of the country that are not presently being served.

Mr. Chairman, I want to commend you for holding these important hearings to look at readjustment programs for Vietnam era veterans. And I want to thank you for allowing me to be an honorary member of the subcommittee today.

As you know, I have a special interest in the Readjustment Counseling Program administered by the VA. I've appreciated the opportunity to work with you, Mr. Chairman, not only in the creation of this extremely effective program, but also in ensuring its efficient operation.

I know you share my view that with the reauthorization of the Vet Center Program for another 4 years, it makes good sense to expand the program to reach veterans who reside in areas not presently served by a vet center. Your subcommittee's capable oversight hearings have compiled ample evidence that the quality of services provided by the vet centers is excellent, as well as cost effective.

I was pleased that our committee included in its report to the Budget Committee a recommendation that an additional 220 FTEE be added to the program. This additional personnel would not require any new appropriations, since money presently allocated to the contracting portion of the program could be redirected to accomplish this expansion. The need for more centers is there, and I believe those charged with operating the program at the VA recognize that need. I simply want to encourage the VA to take whatever steps are necessary to make possible the opening of additional vet centers.

I hope that our witnesses today will comment on the possibilities of adding new personnel to the program to enable new vet centers to be opened. I hope our witnesses from the VA will also share with us their contingency plans for expansion.

I look forward to continuing to work with you, Mr. Chairman, to ensure that our committee's recommendation that 220 additional FTEE be provided to the program is implemented.

Incidentally, Mr. Chairman, I want to point out that additional centers wouldn't cost any money because the money has already been authorized. The VA has the money. Our committee, in its budget report, provided for an additional 220 FTEE's, so the money is there. The VA could redirect this money to accomplish this very necessary expansion. The need for more centers is very, very clear, and I believe that the VA and the VA people who have been working in these outreach centers recognize this and we should do everything we can to encourage the VA to take whatever steps are necessary to open these additional vet centers.

That is my testimony, and I thank you very much.

Mr. EDGAR. Thank you very much. I also want to thank you for joining me in approaching the Appropriations Committee to make sure there is a specific line item in the appropriation for this issue, so that we don't run into the problem which was reported in the media earlier about the shift of funds. We think that the program is now working and can be fully funded.

I agree with you in terms of the expansion of services. We are hoping the Appropriations Committee of the House will work with us in making sure that the funds are dedicated for these outreach centers.

Mr. EDWARDS. Thank you, and thank you for your courtesy.

Mr. EDGAR. Thank you for your testimony.

My colleague, Lane Evans, has an opening statement.

OPENING STATEMENT OF HON. LANE EVANS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. EVANS. Mr. Chairman, I would just like to take a few minutes to commend you for introducing H.R. 4833 and for holding the hearings today. I was with you at the Combat Unit in North Chicago. I think that was an excellent program and it really opened up my eyes. I watched the documentary yesterday that you talked about in your opening remarks, "The War Within," about the Menlo Park, CA, facility. I think that is another good operation.

My problem is that in my State, for downstate Illinois, we have but one post-traumatic stress disorder vet center for all of downstate. They do an excellent job. They are dedicated individuals, under Dr. Shepherd in Peoria, but they are overworked and we certainly need more help throughout my State, particularly in the downstate Illinois area. I look forward to these hearings and an exploration of these issues in the hope that we can get more help for veterans in downstate Illinois.

I thank the chairman for holding these hearings.

Mr. EDGAR. Thank you very much.

Are there any other opening statements?

Mr. Staggers, I want to tell you that we very much appreciated the hospitality that the great State of West Virginia showed this subcommittee when we went out to your State for hearings. We learned some new things, which was real helpful.

Mr. STAGGERS. Mr. Chairman, I want to thank you for allowing the subcommittee to go out and see the unique situation that rural America has, especially in West Virginia. I compliment you, also, for the hearings we are having today and for your leadership in all these issues that you have shown at least to this new member on behalf of veterans.

Mr. EDGAR. Thank you.

We would like to deviate a little bit from the printed agenda that was here. We would like to ask the VA to come in two separate panels. We will allow those who want to stay from the first panel to join the second panel, but I would like to call Dr. Custis, Dr. Brown, and Dr. Blank to the witness table first, and then we will hold Dr. Silver, Mr. Gusman, Dr. Arnold, and Mr. Smith for a second round of questioning, if that's all right.

Dr. Custis, if you have additional people you want to bring to the table, please feel free to do so.

Welcome to the subcommittee this morning. It is becoming almost a weekly event that we sit and talk about health care issues, and I think it reflects more on the size and scope of the veterans health care program than on anything else. I appreciate your coming to share testimony on these two issues today.

Dr. Custis, you may proceed as you see fit.

STATEMENT OF DONALD L. CUSTIS, M.D., CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY D. EARL BROWN, M.D., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR; ARTHUR S. BLANK, M.D., DIRECTOR, READJUSTMENT COUNSELING SERVICE; JOSEPH P. TRAVERS, DIRECTOR, RESOURCE MANAGEMENT OFFICE; RALPH IBSON, OFFICE OF GENERAL COUNSEL; HOLLIS G. BOREN, ASSISTANT CHIEF MEDICAL DIRECTOR FOR RESEARCH AND DEVELOPMENT; AND JOHN O. LIPKIN, ASSOCIATE DIRECTOR FOR MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE

Dr. CUSTIS. Thank you, Mr. Chairman. It is a pleasure to be here. As a matter of fact, the pleasure of being here intermittently makes the interim time pass more pleasantly.

Mr. EDGAR. Dr. Custis, would you introduce the others at the panel who were not mentioned.

Dr. CUSTIS. Mr. Joe Travers, in charge of our budget office; Dr. Art Blank, who heads our Readjustment Counseling Program; Dr. Earl Brown, the Associate Deputy Chief Medical Director; and Ralph Ibson, of the General Counsel's Office.

Mr. Chairman, I will abbreviate the remarks made in the opening statement. We do thank you for the opportunity to appear to comment on H.R. 4833, a bill to provide comprehensive treatment services to veterans of the Vietnam theater who are suffering from

PTSD, and on the operations of the Veterans' Administration's Vietnam Veterans Readjustment Counseling Program.

We consider the effective care and treatment of PTSD, as well as efforts to expand the understanding of health care professionals regarding the diagnosis and treatment of that disorder to be critically important aspects of the VA's responsibilities. We therefore support the objective embodied in H.R. 4833. In fact, we are encouraging the development of PTSD units at our VA medical centers.

Our experience with the treatment of PTSD does indicate a need for additional treatment capacity in the Veterans' Administration. This bill anticipates the development of such additional capacity through designated treatment units. In providing for VA to expand the number of designated PTSD units, the bill appears to call for the development of centers that would have the general cast of VA's GRECC's, blending into one area treatment, education, and research on this disorder. Our clinical care needs are such that we would want to apply the GRECC model judiciously. Indeed, our planning would not be to commit all of our units to a research and education mission.

Mr. Chairman, my full text discusses some additional concerns about the bill as drafted. Incidentally, Mr. Chairman, I think your opening statement does, indeed, clarify and obviate some of these concerns. Others remain, and my staff and I will be pleased to discuss them later if you choose.

With your agreement, Mr. Chairman, I would like to turn to the VA's Readjustment Counseling Program for Vietnam veterans. During the past 4 years the in-house VA vet centers have become the spearhead of the agency's outreach and counseling services to veterans of the Nation's longest and most difficult war. Today, staff are at work in 135 vet centers nationwide, providing a wide variety of services and seeing large numbers of clients, both veterans and family members.

By the end of February 1984, the vet centers had counseled 226,593 veterans and approximately 50,000 family members since the program began in late 1979. The Vietnam veterans response to VA outreach efforts is a happy outcome of the Veterans' Administration's efforts to serve Vietnam veterans. With over a quarter of a million persons seen, by all indications we do believe we are experiencing very high client satisfaction with services.

The original design of the program has proved effective, relying on about 60 percent of staff who served in Vietnam, with an additional 15 percent being Vietnam-era veterans. There are currently 556 professionals and paraprofessionals providing direct readjustment counseling services at 135 vet centers. Six regional managers and staff have direct line supervisory responsibility over the vet center staffs.

Now I would like to proceed, Mr. Chairman, with the status of the readjustment counseling fee-for-service contract program. Following a protocol formulated by the Readjustment Counseling Service in 1979, contracting committees at over 100 sites, including both medical center and vet center staff, awarded competitive contracts to 530 individual practitioners, group clinics, and community agencies across the country. Through the end of February 1984, the contract providers had seen a total of 23,016 veterans for a total of

165,290 visits. Expenditures for the contracts program have increased steadily since fiscal year 1981 and close monitoring of this program is a needed improvement. On October 19, 1983, a task force was appointed and charged to develop a plan that formulated a mechanism for monitoring the readjustment counseling fees/contracts programs. In January 1984, a letter was sent to each medical center instructing them to conduct an internal control review of the fees/contracts program. This phase of our internal management was completed last week. We are now analyzing the data and we expect to take immediate action toward resolving the problems identified in our nationwide survey. It will not be easy, Mr. Chairman.

While fully in place as an operational entity, the contracts/fee program is not problem-free. Our early concerns for utilizing this authority were that we would have limited control over the quality and the integrity of the contract services provided. Our concerns have been borne out and the VA Inspector General has reported findings indicating a need to determine client eligibility in a more timely manner and to require that contractors provide formal documentation to evidence that billed services have been provided to clients. Department of Medicine and Surgery program officials have worked closely with the Inspector General in developing the audit plan to detect the program areas of vulnerability.

Based on our experience, Mr. Chairman, we prefer the VA vet center approach over the contract program. In our centers, about 40 percent of our clients are troubled by post-traumatic-stress disorder to some varying degree. About 50 percent have a variety of readjustment problems in other areas, and perhaps 10 percent are seen primarily for evaluation and referral. A substantial number of the veterans with PTSD also have other life problems. Overall, as has been the case since the program's inception, employment difficulties remain a very common presenting problem.

The greater-than-expected percentage of clients with stress disorder, some of whom are severely troubled, has required the provision of extensive counseling and psychotherapy. We have, therefore, increased the proportion of staff who are mental health professionals now requiring at least one at each vet center, and we have been compelled to maintain an intensive in-service training program nationwide in order to enhance the skills of the paraprofressional and nonprofessional staff.

In conclusion, Mr. Chairman, we feel that all the changes and refinements in management which are taking place at all levels, from Central Office to vet centers, are occurring without diluting or detracting from the unique features which have made vet centers so responsive to Vietnam veterans; namely, a high proportion of Vietnam veterans staff, a mix of professionals and paraprofessionals, informality in atmosphere and procedures for clients, community location and orientation, and clarity of program goals and objectives.

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the committee may have.

[The statement of Dr. Donald Custis appears at p. 63.]

Mr. EDGAR. Thank you very much, Dr. Custis, for your statement.

I would like to suggest to my colleagues on the committee that we divide the questioning into two parts, and that our first line of questioning focus primarily on the readjustment counseling centers and its program, and then, once we have exhausted those questions, we will shift to the issue of post-traumatic-stress disorder, which is the second issue that we're dealing with here at the hearing. Let's have those two rounds of questions for this panel and then we will bring the second panel on.

Dr. Custis, how many veterans are being seen in readjustment counseling centers, what percentage of the target population have we reached with these centers, and could you provide a comprehensive analysis for data sheet concerning the workload at the vet centers at this time?

Dr. CUSTIS. We have that and can provide it for the record. I am sure Dr. Blank would also like to comment on it.

I will start off by saying there have been varying estimates of incidence, from 400,000 to 700,000. Hopefully, this will be better identified in the needs assessment survey that is about to get underway. Our in-house vet centers as of now have seen something over 220,000, with an additional 50,000 family members. I will now ask Dr. Blank to pick it up from there.

Dr. BLANK. We will be happy to provide a comprehensive analysis of our client experience to date. I think I might mention a couple of high points.

Currently, vet centers nationwide are seeing, for this fiscal year, an average of about 6,300 new veteran clients per month, and around 18,000 total different veterans per month.

With regard to the percentage of the target population which has been reached thus far, it is important to make a distinction between Vietnam theater veterans and Vietnam era veterans. As you know, the vet centers provide services to both groups. Our best research indicates that as of 1980 somewhere between 700,000 and 800,000 theater veterans were in need of services from this program. Thus far we have seen about 200,000 of that group.

Mr. EDGAR. Let me ask you two questions: One, you both indicated you would submit this information for the record. What are we talking about in terms of timing? Do you mean today?

Dr. BLANK. I have it here.

Mr. EDGAR. You have the information there. OK.

[Subsequently, the Veterans' Administration furnished the following information:]

Readjustment Counseling Service: Monthly status report for month of May 1984

Total vet centers:	
Vet centers	125
Satellites	11
Total operational	136
Average number of months vet centers open	44

	Current month	Fiscal year to date	Same month last fiscal year	Same months in last fiscal year	January 1980 to date
PRODUCTIVITY					
Total number of new veterans seen	7,160	51,070	5,240	45,635	246,063
Total number of veterans outreached	1,096	7,887	972	8,025	56,995
Total number of all veterans seen (old and new cases) cumulative of monthly totals	22,909	86,060	18,127	76,249	432,895
Total number of 45-minute equivalent visits (by veterans) (contacts divided by 3)	67,916	439,003	54,318	421,954	2,028,493
Total number of collateral visits	6,581	40,996	4,865	41,702	225,542
Total number of collateral persons seen					
Total number of calls made in behalf of veterans	9,169	66,846	8,393	77,442	468,206
STATUS OF CONTRACTING PROGRAM, APRIL 1982 TO DATE					
Total number of contracts signed during this month					
Total number of contracts signed since April 1982					544
Total number of contracts not reawarded this month					
Total number of contracts currently operational	544	544			
Total number of veterans seen by contractors	4,198	10,876	2,342	6,499	34,378
Total number of veteran visits to contractors	13,894	90,003	8,073	51,669	202,444

Mr. EDGAR. It would be helpful if we could have that as a critical part of the record as early as possible, and I would like to make that also available to each of the members on the subcommittee.

Could you also answer the question on the way the statistics are kept. Are there some services provided at the vet centers that don't get adequately recorded in the numbers?

Dr. BLANK. Yes. The vet center staff, as Congress intended, provide a wide variety of services and activities, including consultation to professionals in the community about the problems of Vietnam veterans, both VA and non-VA professionals, as well as outreach, and also including community education. This is all in addition to the work of providing direct treatment services in vet centers.

Mr. EDGAR. It is real helpful, I think, given some of the recent comments about the vet centers, to have a fairly accurate knowledge of what is being done by the vet center staff. It is our understanding, from our field visits, that the centers are not only being used, but in many instances there is a lack of resources to fully do all of the things that they could be doing.

I wonder if you have any statistics on whether or not any veterans are being turned away from any of the centers.

Dr. BLANK. We don't turn veterans away. Everyone that comes is seen. The limiting factor, of course, has to do with the amount of time that can be spent with a particular veteran.

I might say that I caused to have done last year a systematic time study of vet center staff nationwide which indicates more precisely the amount of time spent by counselors and also team leaders on various activities, which we would be happy to provide you with.

Mr. EDGAR. Without objection, a summary of that will be provided for the record.

[Subsequently, the Veterans' Administration furnished the following:]

As requested, attached are:

1. Time Management, Evaluation, and Function of Operation Outreach Vet Centers by Center and Region.[1]

2. Time Management Functioning of Rural vs Urban Vet Centers: Outreach Activities of Operation Outreach.[2]

Mr. EDGAR. Let me ask you about the contract program in the vet center area. Can you explain why the VA has persistently overestimated the funds necessary for the contract portion of the program and would you comment on the charges that these funds could have been spent on Vietnam veterans?

Dr. CUSTIS. Mr. Chairman, we have, indeed, overestimated the resources we required for the contracts program, overestimated in terms of the productivity that we expected from contractors and the demand for services from contractors.

There is another part of that answer that lies in the fact that we were slow in getting the contract program implemented. I think one of the primary reasons for that slowness was that there was considerable concern as to whether there could be quality control over the contracts and a reluctance to embark upon them until Congress made it very clear that they did, indeed, want this portion of the program implemented.

I think the timing of the emphasis on the contract program began with the arrival of Dr. Arthur Blank as program director. From that time on there was a relatively rapid implementation of contracts that have now reached a level that we think probably has stablized at something over 500. Concerning the resources required, if the contract program were indeed stabilized now, I think we have learned from experience that something in the neighborhood of $8 million is what would be needed to keep it at its current level.

The other portion of your question, as I understand it, is the concern about how leftover funds were utilized in past years. In 1981, we had no indication that there was any fencing of that money, and in the last quarter we made the decision—and in 1981 practically all of that money was unobligated by the last quarter—we made the decision to distribute it to our hospitals for the purpose of augmenting their resources on the rationale that there had been no new resources provided to fund the expanded eligibility for VA care for Vietnam veterans.

There was immediately criticism of that action and the House Appropriations Committee the following year made it clear that they expected greater accountability of the $11.2 million earmarked for contracts and requested that we keep them informed and seek their guidance as to any future reprogramming, which we did in the subsequent years of 1982 and 1983. In 1982, that mandate in Public Law 97-257 was that the leftover funds be devoted to the nurse scholarship program, and in 1983 the leftover funds were congressionally transferred by Public Law 98-63 to support the ADP integrated hospital system.

There was, I assure you, consideration given in each year to other uses, more directly related to readjustment counseling, one of which would be to expand the in-house VA vet centers. We were then and still are, however, unable to do so because we do not have the manpower, the FTEE, to lay against those dollars.

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[1] See p. 82.

[2] See p. 109.

Mr. EDGAR. Dr. Custis, could you just emphasize—I think what you have said is that all of the reprogrammed money stayed within the veterans' health care system?

Dr. CUSTIS. Yes, sir.

Mr. EDGAR. It is important to underscore that, as though there were some impressions left, which I think were erroneous, that those funds were somehow diverted to something that was non-health care related.

Dr. CUSTIS. Oh, yes. Dr. Brown reminds me that some small portions of that money lapsed and reverted to the Treasury.

Mr. Travers may want to also add to the answer to your question.

Mr. TRAVERS. Essentially what Dr. Custis has said, Mr Chairman, is correct. All moneys stayed within the VA health care system or was lapsed at the end of the year. In 1982, from the contract program, we lapsed $2.2 million, and in 1983 we lapsed approximately $900,000 from the contract program.

At the time we met with the congressional committees on the reprogramming of the $8 million and the $4.2 million in 1983, it was during a period of time just prior to the end of the fiscal year and they selected the amount of dollars that they would have go for reprogramming in support of the scholarship program and in the IHS program by appropriations legislation.

Mr. EDGAR. Thank you.

Dr. Blank, do you have any figures to compare the cost effectiveness of the in-house center treatment versus the contract treatment?

Dr. BLANK. Yes, we do. We have hard figures in the case of vet center visits. The vet center visit costs about $19.60 per visit for personal services, and about $31 per visit, all overhead included. In the case of contract providers, we have only an estimate, although it is probably a pretty good one. The reason why we don't have hard figures is because the rates which people in the private sector charge vary greatly. We think that the rate per visit for the private providers is somewhere between $45 and $50 a session.

Mr. EDGAR. So you're indicating it is probably more cost effective to do it in-house, if that's possible. Sometimes with the remoteness of the area it is not possible to do it in-house; is that correct?

Dr. BLANK. That's correct.

Mr. EDGAR. Dr. Custis, on December 19, 1983, I wrote to you requesting that the VA consider phasing back the contract portion of the readjustment counseling program using those additional and excess funds for an expansion of the services provided through the establishment of additional in-house vet centers.

Without objection, I would like to place my letter, as well as your response, dated February 22, 1984, into the hearing record at this time. Without objection, we will do that.

[The information appears at pp. 123 and 125.]

Mr. EDGAR. In your letter you state the following:

> Readjustment Counseling Service has recently completed a review of staffing needs of the vet center and is developing criteria for the enhancement of existing centers and the selection of new sites. We are evaluating various ways of funding

additional and expanded centers, including seeking Congressional approval to reprogram excess funds from the earmarked fees/contract program and acquiring additional personnel ceilings to staff these centers. A listing of additional sites will be developed in case additional resources become available.

The question I have for you is, has the Readjustment Counseling Service completed its review of the staffing needs of the vet centers? Have they developed the criteria for the enhancement of existing centers and the selection of new sites? Have you developed the list of additional sites, and have you sought or do you plan to seek congressional approval to reprogram funds to acquire additional personnel to staff these centers?

Dr. CUSTIS. The answer is yes, I believe, Mr. Chairman, to almost every portion of your question. The survey has been completed, criteria have been developed, and sites have been selected. They are listed, along with recommendations identifying various options for utilization of unused funds, this current year. Those recommendations are currently with the Administrator and he has them under consideration and will undoubtedly give us some guidance within the next few weeks.

Mr. EDGAR. If we are successful in getting the additional FTEE for this program, will you have any problems in obligating fully those additional staffing positions?

Dr. CUSTIS. Well, the later we get into the fiscal year, I think the more difficulty we will have on the FTEE matter, simply from a time crunch. As far as the dollars go, I think we can act in reprogramming the dollars for other purposes on a last-minute basis.

Mr. EDGAR. We're talking about raising this personnel ceiling starting October 1, or are we talking about——

Dr. CUSTIS. I thought you were referring to the possibility of availability of FTEE——

Mr. EDGAR. Of doing it this year.

Dr. CUSTIS. This year.

Mr. EDGAR. OK. Let me yield to my colleagues for additional questions on the readjustment counseling centers, and then we will get back to the post-traumatic-stress disorder.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Blank, did I understand you to say that we have a record of treating approximately 200,000 veterans in this readjustment counseling program, and that there is a total need of anywhere from 700,000 to 800,000?

Dr. BLANK. That is our best estimate, based on the available research to date.

Mr. BILIRAKIS. How do we come to that type of an estimate?

Dr. BLANK. There are two, and only two, nationwide studies which bear on this matter, both of which were carried out with the support of the Veterans' Administrations. A nationwide survey was done by the Lou Harris organization under contract with the VA, and a nationwide epidemiologic study was carried out by the Center for Policy Research in New York City. Both of those, which require careful reading to understand—as is always the case with such research, what they say—both of those indicate that this is about the number of our target population.

Mr. **Bilirakis**. These surveys, studies or whatever, did they interview Vietnam veterans?

Dr. **Blank**. Yes, sir. They are based on interviews.

I should say that in relation to the new needs assessment study, which we are about to embark on, that both of these projects now are rather dated. They refer to the situation as of the late 1970's.

Mr. **Bilirakis**. This is the result, then, of a veteran admitting to somebody that he may need readjustment counseling?

Dr. **Blank**. Yes.

Mr. **Bilirakis**. Is that basically what it comes down to?

Dr. **Blank**. Yes. In the case of the Harris survey, the interviews were rather brief. In the case of the Center for Policy Research study, the interviews were rather thorough and more to the point.

Mr. **Bilirakis**. Do we have names of these veterans, then? Do we have 700,000 or 800,000 names, addresses, that sort of thing?

Dr. **Blank**. No, sir. This is based on a sampling approach, as is the case with any nationwide epidemiologic study. One studies a certain portion of the total population and then makes statistical projections to the entire population.

Mr. **Bilirakis**. I see.

How do we get to these additional 500,000 approximately who apparently need this help and let them know that this help is available, and, of course, how do we then make the help available to them, and why are we not making the help available to them, and why are we not getting to them?

Dr. **Blank**. In the case of vet centers we are getting to them at the rate of, this fiscal year, of approximately 6,000 a month.

Mr. **Bilirakis**. All right. What's the need there per month? How much of a need is there? We're getting to them at the rate of 6,000 per month, so what's the need, 10,000 per month, 15,000 per month? Or do we extrapolate the proportion of 200,000 versus 700,000 and use that percentage figure?

Dr. **Blank**. That is a very important question and a very difficult one to answer because of the fact that the surveys on which our data are based are now rather dated. It is very difficult to know what the rate is at this point in time. We think it is more than we're doing, and we're looking to our needs assessment survey to answer that question for us.

Mr. **Bilirakis**. In terms of dollars, can we answer that question?

Dr. **Blank**. I'm not sure I understand the question.

Mr. **Bilirakis**. Well, I suppose, the way I interpret the byplay regarding the contracting out, it is that everybody seems to feel that contracting out is not as efficient and that sort of thing. There has been a surplus of dollars there lapsing. It has been used for veterans' purposes and we are all certainly united as far as the decision there is concerned to use those dollars.

But what I am wondering, is it lack of dollars that is preventing us from getting to all of these veterans, to let them know that these services are available for them, and then making these services available for them? If it is lack of dollars, then where are these dollars going to come from, and have they been used possibly for another purpose and should they be, in fact, earmarked for this purpose? I'm not making a statement, I am asking a question.

Dr. CUSTIS. In the first place, Mr. Congressman, I think at this point we can't answer the question as to what is the need and how many dollars it would take to respond to that need. We hope to be in a better position to do so after the epidemiologic study results are in.

During the past 2 or 3 years we, indeed, could have gotten to more veterans had we had more manpower to open more vet centers. That's a retrospective judgment. The contract program, I think, just in the last year, has given us reason to have doubts about depending so heavily on it. We would much prefer to cut back on the contract program. We do need contracting in certain geographic areas, but not to the extent we have it now, because we simply can't maintain quality control. So the bottom line is, while we are waiting for the epidemiologic study results, we do need more manpower to open more vet centers.

Mr. BILIRAKIS. Yes; I go along with that, sir.

What was the date in terms of getting these results, Mr. Chairman? I believe that answer was given to you. What sort of a date are we looking forward to as far as getting these final results so that we can make proper decisions?

Dr. CUSTIS. Dr. Blank assures me that that will be available in October of 1986.

Mr. BILIRAKIS. October of 1986.

Dr. CUSTIS. We'll make him remember that promise.

Mr. EDGAR. Would the gentleman yield?

Mr. BILIRAKIS. Yes, sir. My time is up.

Mr. EDGAR. I think we are talking about three separate things on this particular issue. We are talking about the epidemiological study—and you have given a date of October 1986 for that study, correct?

Dr. CUSTIS. Yes.

Mr. EDGAR. The second issue, though, is the need to begin something now, given the basic analysis that has been made. As I understand it, there has been an analysis made by Dr. Blank and others about the needs immediately.

I guess the real question is, has the VA requested of OMB the opportunity to expend funds now to shore up the existing centers?

Dr. CUSTIS. No, sir, that has not gone to OMB. The options are currently under Mr. Walters' consideration.

Mr. EDGAR. The question I think we have to ask then is, when will we get those options? You testified just a few minutes ago that the longer we wait, in terms of implementing the list of needs, the harder it will be to obligate and get the program in place isn't that correct?

Dr. CUSTIS. If we are to do recruiting for more teams in the VA, the longer we wait, there will be a time crunch on such recruiting this fiscal year.

Mr. EDGAR. So what would your hope be in terms of the timing of that, in terms of Mr. Walters' decision, the request of OMB, the request within the Department to move on the shopping list of centers that you have developed in the expansion of services?

Dr. CUSTIS. I'm a little uncomfortable in giving an answer. I think Mr. Walters has every intention of addressing this in the very near future and I would expect we would have his guidance within the next 2 weeks. I am uncomfortable in that he has given me no indication of what he is going to choose in the options provided him.

Mr. EDGAR. The third issue is the issue of staffing. We made a request within the House budget, and the Senate has made a similar request, and we have included the money in the budget submission and we believe it's on track. We are urging the Appropriations Committee to fund the additional 220 persons. That would be for fiscal 1985.

If you were able to start now the beginning process of that and come out running effective October 1, 1985, with the additional 220 staffing position, would that make much more sense in terms of providing that service than delaying it on into the 1985-86 timeframe?

Dr. CUSTIS. This is a difference between a personal opinion and a policy guidance.

Mr. EDGAR. I am asking for your personal opinion.

Dr. CUSTIS. I think the sooner we would get started, the easier it would be in terms of next year.

Mr. EDGAR. One final question.

When I asked you the shopping list of questions at the end, about my letter to you and your response, and you said yes to the number of centers, the criteria, the selection of new sites, the additional sites, may we have a copy of that for the committee record?

Dr. CUSTIS. This is part and parcel of the material that is on the Administrator's desk, and——

Mr. EDGAR. When will that be made available for congressional consumption?

Dr. CUSTIS. There is the business, you know, of whatever is decided, of going to OMB and——

Mr. EDGAR. But the material is in hard copy form, placed on Harry Walters' desk?

Dr. CUSTIS. Yes, sir.

Mr. EDGAR. And it will be available at some time coterminous with the announcement?

Dr. CUSTIS. Yes, sir.

Mr. EDGAR. Thank you for your answers to those questions.

Mr. Staggers.

Mr. STAGGERS. No questions.

Mr. EDGAR. Mr. Penny.

Mr. PENNY. Mr. Chairman, only one question.

The appropriation for contracting for outreach and counseling is several million in excess of what has been spent in the last few years, and the money has then been reprogrammed. If we don't direct this year that the money be utilized to open up more storefront centers and pay for the staffing, what would the VA's recommendation be for that surplus $7 million?

Dr. CUSTIS. Again, I am not sure of my authority to identify the options that we have presented to the Administrator. I can give you some "for instances" without specifically spelling out those options.

For instance, the total balance would appear to be something less than $3 million this year. One option would be to transfer that money to the research budget in order to not have it lapse at the end of the year and use it to pay for the epidemiologic study.

Incidentally, there is no separate appropriated funding for that study, as I recall. Is that right, Joe?

Mr. **Travers**. That's right.

Dr. **Custis**. That is one example. I could go on giving other examples, but I think clearly the greatest priority, in terms of need, is to utilize it for direct care of the Vietnam veteran. The best way to do that is more in-house programming.

Mr. **Penny**. Dr. Custis, do you have a report to the Administrator of various ways in which those dollars could be utilized?

Dr. **Custis**. Yes we have presented to the Administrator the criteria for opening more centers, the site selection for more centers in a prioritized fashion. There is a hard list of them and optional ways to reprogram leftover funds.

Mr. **Penny**. I guess I missed the point on the reprogramming. I recognized the discussion that was going on about prioritization of the centers, but I wasn't clear that you had also listed in there other uses for those dollars if they were not utilized for centers.

Thank you.

Mr. **Edgar**. Mrs. Johnson.

Mrs. **Johnson**. Thank you very much.

Just very briefly, Dr. Custis—and I appreciate the quality of your testimony this morning—you are concerned in H.R. 4833 about the preference for a specific program model, the appearance of a mandate of that model.

Could you enlarge on your concerns along that line? Are you thinking about other approaches? Are there other approaches within the system? From your experience, what is the desirable spectrum of alternatives that we need to have in place?

Dr. **Custis**. Mrs. Johnson, the GRECC model is a very good model. As we expand the GRECC's, however, there are locales that simply do not have the talent to do, by comparison, a good job of research, but they may have a lot of talent in the case of patient care and education. So we would modify that GRECC model at that locale to maximize local potential.

Similarly, if we were to utilize a similar model for in-house hospital PTSD care, we would like to have that same flexibility. We have already committed ourselves to the opening of such a center at the Cleveland-Brecksville VAMC. That will, indeed, follow the pattern that is identified in this legislation. It is just that to repeat that same thing in 15 locales may be a little too rigid for the best results.

Mrs. **Johnson**. Your point about the education and research component is a very good one, and also about not wanting to repeat the same identicial program. What I was really wondering about is, do you have any indication, from your experience, that as good as these programs are—and I think we are all in concurrence that the model is a good one—that there are those who prefer to be treated in the general clinic or some program that has a broader identity.

Do you run into any of that, Vietnam veterans who actually are suffering from this malady but prefer a different setting for treatment?

Dr. CUSTIS. I really think I should defer, Mrs. Johnson, to the two psychiatrists that are sitting to my right.

Dr. BROWN. Mrs. Johnson, I think it is important that we have the full spectrum of treatment available to veterans with PTSD. There is no question but what the disorder itself is one which, when an individual is confronted with sufficient stress in order to develop symptoms, there is a natural tendency for recovery unless something gets in the way. What we are talking about is treatment of those who had something get in the way.

We have been treating them for quite some time in our mental health clinics, and very satisfactorily. There are certain populations that are amenable to that type of treatment. There are others who need brief in-hospital time. There are others who will respond only to the type of setting that you have visited, that is, the post-traumatic stress disorder unit.

I think it is important to have the full spectrum because everybody doesn't need one specific type of treatment.

Mrs. JOHNSON. One last question.

Could you clarify for us what is the major difference or major couple of differences between the criteria that you were recommending for oversight of contracting programs that you think will enable you to assure the quality of those programs more effectively?

Dr. BROWN. If I understand your question, what are we doing in order to——

Mrs. JOHNSON. Well, you talked about setting some clearer criteria, so that you could be certain that they were doing what they were supposed to do. Now, clearly, when you first set up the contracting program you certainly set some guidelines. I mean, you weren't without criteria. I just wondered, from your experience, what are the two or three things that you're either focusing more intensely on or adding that you think will give you greater control over the contracted portion of treatment programs?

Dr. BROWN. In the contracting program, of course, our most recent request for proposals was very tight. So it is a good control document in itself. In addition, the guidance we had given to the field originally included some good controls.

What we have learned, though, in our experience with the contract program is that there are certain areas of vulnerability, such as treating ineligible veterans, for example, or treating others who are not authorized. So we have generated a whole list of problem areas that have been identified both by us and with the assistance of the inspector general. These have been sent out to the field, placing the program under A-123 for a special internal review. This went out in January. We have asked that each of the contracts be reviewed in light of the problem list that we have sent, and a report be sent to central office this month. We are currently receiving those reports and we will analyze them and then identify even further what the problems with the contracts are.

In addition, we convened a task force to assist us with this, to recommend various methods so that we might exercise tighter control. That task force has reported and the idea that I just gave you came out of that task force. They are also developing a SCEM, a go-by, for assessing each one of these contract programs, and they have recommended that we put in place in each general geographic area an individual for visiting the contractor and reviewing with the control document exactly what is being done so that we can assess exactly the quality of care that our veterans are getting and to ensure they are getting what we're paying for.

Mrs. JOHNSON. Thank you very much. I think a lot of us would be interested in the final report that comes out of that.

Mr. EDGAR. Before I yield to my colleague, let me indicate—and I apologize to Mrs. Johnson for not mentioning this—but we are going around a second time on the issue of post-traumatic-stress disorder. We would like to focus, if we could, just on your final questions on the readjustment counseling centers, if possible, and then we will get to the post-traumatic issue.

Mr. Daschle.

Mr. DASCHLE. Thank you, Mr. Chairman.

I haven't asked the question, and it may have been asked by someone prior to the time I got here. Dr. Custis, can you tell me what the purpose was in reprogramming 40 percent of the contract care money? I know that it went through the proper channels. But it was reported that 40 percent of all the contract care money was used for other purposes. Is that figure correct?

Dr. CUSTIS. The cumulative amount, over a period of several years, does amount to something close to $40 million.

Mr. DASCHLE. Oh, it's $40 million and not 40 percent of their budget?

Dr. CUSTIS. There was no purpose that drove reprogramming of funds. There was a need to make meaningful use of unused funds, and several options each time were considered.

Mr. DASCHLE. So most of the money——

Dr. CUSTIS. In other words, it wasn't a premeditated, purposeful withholding of funds from the program. The program simply didn't utilize the funds that we expected it to.

Mr. DASCHLE. I'm troubled by that. Every time I go to an outreach center I get two complaints. The first is that there just isn't enough money allocated to each one of these outreach centers for staff and especially for travel. In South Dakota, of course, we have two, with wide open areas, and a great, big service area. They just are incredibly underbudgeted.

I was up to Connecticut just a couple of weeks ago and I heard the same comment there, even though it's a much smaller State and a smaller service area. So I am troubled why Washington would think there isn't any need for the money, and yet, when you go out to the outreach centers themselves, you find that there seems to be a tremendous under-budget and a lack of adequate funding for the kinds of services they provide.

How would you address that dilemma?

Dr. CUSTIS. We have got to separate two pieces of the funding year after year. The first year we did not consider that there was any need to come back to Congress to ask how to utilize the unused funds. We were——

Mr. DASCHLE. Would you stop there for just a second. Define for me what "unused funds" would be. What were they allocated for and how were they not used?

Dr. Custis. This really is beginning to sound like a broken record. The Congressional Record is full of these answers.

Mr. Daschle. I apologize, but maybe you could just review it for me.

Dr. Custis. The point is, beginning in 1982, for all intents and purposes, not directly in law but by direction and guidance of the House Appropriations Committee, the contract portion of those funds was fenced. We couldn't use it for any in-house vet center need. It was fenced for the purpose of contracts.

We overestimated in 1982 and 1983, and again in 1984, but to lesser degrees each year, how many dollars the contract program would absorb. So we share your concern, that it's very unfortunate that year after year that funding couldn't have been used for the in-house readjustment counseling program. But it could not. It was ostensibly, or for all practical purposes, fenced——

Mr. Daschle. What does "fenced" mean?

Dr. Custis. Meaning that we have direction from Congress, or from some authority—OMB has the same prerogative of telling us we may not spend money for anything but what it has been identified for.

Mr. Daschle. OK. What were they telling you to spend it on that you found——

Dr. Custis. Contracts.

Mr. Daschle. Contracts for what?

Dr. Brown. Readjustment counseling contracts.

Mr. Daschle. But that's a wide open area. Obviously, that doesn't give you enough latitude because you're coming up with a problem here and for what they're telling you to use that money for, you haven't found enough of a need. So what I'm trying to understand is what is it they're telling you to spend that money on that you haven't found a need for that comes up with this $40 million?

Dr. Custis. I'm not sure I understand the question adequately to be able to give an intelligent answer. It's a very specific thing, contracting for the——

Mr. Daschle. Specifically, what is it?

Dr. Custis. There is authority that has been delegated to all of the vet centers to advertise, evaluate, and award contracts to individual counselors or groups of counselors, to do essentially the same thing—that is, readjustment counseling, with some modifications for Vietnam veterans.

Mr. Daschle. All right. I'm with you so far.

Dr. Custis. Now, there is a great variation in the productivity of these over 500 contracts. If they all were as productive as some of them, we would need twice the amount of $11 million.

Mr. Daschle. So, in other words, you have spent all that you thought you would have in writing these contracts with people, and what they have come back to you to say is, "Look, we haven't needed all the money, even though we have expended everything the authority will allow for the contracts that you can write under the authority that you have from OMB and us," and you're coming up with a shortage not of your own volition. This isn't something that you anticipated, is that correct?

Dr. **Custis**. Well, the contracts are fee-for-service. We have to wait and see what the utilization is month-by-month.

Mr. **Daschle**. But when you found an underutilization in the past, why would it not have been possible—and this will be my last question, Mr. Chairman. I'm just puzzled by this.

I am told that you haven't been able to spend the money for contracts. It would seem to me then the next best thing to do would be to write more contracts. If you have more money, write more contracts. Obviously, if you can't do it in-service, you have got to write more contracts to make up for what money you don't have within the service to do it, to supplement that in-service.

Then you write more contracts, you make up the $40 million, and the problem is solved. But you're saying you can't do that because somebody is telling you the fence, the term you used, is too restrictive. What I am trying to figure out, if it's too restrictive, then let's not make it so restrictive. There has got to be a problem here that I still don't understand.

Dr. **Brown**. Mr. Daschle, this is a very highly specialized area. There are relatively few mental health professionals who are experienced and who have the qualifications in order to do readjustment counseling. We allowed the contracts to go as far as they would. We sent the authority out to 120 medical centers and all of our vet centers in order to let these contracts, with the understanding that they would let as many as they had applicants to do so. The money that was spent, that's how far it went.

If there were others out there who were capable of fulfilling the RFP, we would have let more contracts. But there were not.

Mr. **Daschle**. I see. So for the authority you have, you just haven't had the business. People haven't come in to say "we want to work."

Dr. **Custis**. Right.

Dr. **Brown**. That's right.

Mr. **Daschle**. Have you advertised it? Have you really made an effort to find these contractors?

Dr. **Custis**. Oh, yes.

Mr. **Ibson**. It is important to add, Mr. Daschle, that we're talking about qualified contractors. We have regulations which detail, pursuant to the implementing statute, the criteria which contractors have to meet. We didn't find enough contractors to meet those criteria to spend the moneys in question.

Mr. **Daschle**. Well, I'm out of time, and I apologize for taking more time. It seems to me that's a different question than the fence problem that Dr. Custis addressed earlier. You're talking here about an eligibility problem that you yourself have probably written into the requirements. But it's not a fence problem. It is not something we have to deal with.

I thank you, Mr. Chairman.

Mr. **Edgar**. Thank you very much.

I yield to my colleague from Florida, Mr. Bilirakis.

Mr. **Bilirakis**. Thanks, Mr. Chairman.

I apologize, I know I used my time previously, but I have wondered about this and I think my colleague from South Dakota was certainly touching on it very strongly.

I would like to ask a basic question. Is Congress shoving contracting out down the throats of the Veterans' Administration?

Dr. CUSTIS. Without agreeing to that term——

Mr. BILIRAKIS. Well, it's a strong term, but I wonder if that doesn't cover the area.

Dr. CUSTIS. There was a point in time when we were slow in getting the contract program implemented, and I think all of the committees—the oversight committees, the appropriations committees—were critical of our not getting on with it and made quite clear their interest in our implementing the contract program.

Now that we have some experience with it, the same committees I think also understand that it is not the ideal solution. As far as we recognize, there is no longer any pressure coming from any one of the involved committees.

Mr. BILIRAKIS. But then, hitchhiking upon the question asked by my colleague from South Dakota, if you were not required to contract out—I think you used the word "authorized" earlier, but it almost seems like a mandate here, because $11-plus million is allocated for contracting out. If you had the authority to somehow use that money to better serve the needs of the particular veteran, let's say the Vietnam veteran for purposes of this discussion, by not contracting out, would you find a better way to be able to do it?

If you were given the authority to hire additional professionals in this field, who could serve the veteran better, and in a much more efficient and obviously cheaper manner—because there was testimony to that effect earlier, which means the dollars could be spread out that much more—could you do so? Are those people there that the VA could hire? Apparently you're having trouble getting adequate professionals for contracting out, but are they there for hiring purposes as far as the VA is concerned, if you had the FTEE authority, et cetera?

Dr. CUSTIS. I will let Dr. Blank tell you about our experience in recruiting, but before he starts, the answer to your question is yes.

Mr. BILIRAKIS. OK.

Dr. CUSTIS. I think the whole experience with this contract program and the resource fencing is one that illustrates very well that administrative authority—in this case, the agency, the Department—does much better if there is flexibility in the application of a program.

Mr. BILIRAKIS. OK. Then I think the answer was yes to my first very brash question. Thank you, Doctor.

Mr. DASCHLE. Mr. Chairman, could I ask one additional question?

Mr. EDGAR. I'm going to yield to my colleague and hear the response, and then I would just simply say we do have another panel and two panels of veterans organizations to hear from. I do have a dinner that I have to get to tonight. [Laughter.]

I am willing to stay, but I need to make sure we cover it in a reasonable amount of time.

Mr. DASCHLE. The chairman is always very generous with his time and I am grateful.

Dr. Custis, I was under the impression that you said you didn't have the authority to use contracting money for your in-house staff purposes. That is not true. You do have the authority. You just don't have the number of staff positions currently which would allow that. But you can shift that money.

Now, what I am going to ask you is this. If we can pass within our budget the additional numbers of staff that we are hoping to authorize here, will you then shift some of the contract money to the in-house to hire the additional staff that I guess we both agree are needed?

Dr. CUSTIS. It is up to the Appropriations Committee to transfer those funds, to remove the fence, as I understand it, and I will defer to those who know better.

Mr. EDGAR. Would the gentleman yield at that point?

I think it is correct, that the Appropriations Committee can remove that fence. Isn't it also true that the Office of Management and Budget could, in and of itself, remove that fence?

Mr. DASCHLE. Yes; it is.

Mr. TRAVERS. You are dealing with two different things, Mr. Chairman. The first part, about the movement of dollars between the in-house program and the contract program, we have a congressional monitoring system that is in effect, where on a quarterly basis we have to meet with the Appropriations Committees of both the House and Senate, in which we discuss with them where our dollars are being expended throughout the various appropriations. We are asking them for permission to move dollars that are fenced from one area to another.

Mr. EDGAR. Is that in conjunction with OMB making that request?

Mr. TRAVERS. No, sir.

Mr. EDGAR. But could OMB make the request of changing the dollars?

Mr. TRAVERS. OMB could make the request, sir, but it would fly through the route of going through being approved by the President and then being sent to the Appropriations Committee.

The problem of the ceiling——

Mr. EDGAR. Has OMB made that request at any time?

Mr. TRAVERS. No, sir; they have not.

Mr. EDGAR. Wouldn't that make it easier with the Appropriations Committee if, through Harry Walters, a request was made to OMB, to the President, to come up and request a shifting of those dollars?

Mr. TRAVERS. The Appropriations Committee could do it without going through OMB, sir.

Mr. EDGAR. That's correct. But if OMB and the President were urging that shift, wouldn't that grease the skids?

Mr. TRAVERS. It would probably be an extra step in the procedure. I think we could deal directly with the Appropriations Committee. We have gone through the first congressional monitoring system this past year——

Mr. EDGAR. I'm just wondering whether or not—the Appropriations Committee says to us "We don't have that request from the administration. The VA comes up and asks to shift it around, but OMB doesn't make that request."

Mr. TRAVERS. I'm wondering if they're talking about dollars or ceiling. The obvious thing, if we're going to increase the ceiling, you have to get the authorization from OMB to give the VA additional ceiling.

Mr. **Edgar**. OK. If there are no additional questions on this topic, I do want us to shift—and I apologize to those who have been waiting patiently, and we will hear from our second panel in a moment. I just felt that we were really dealing with two different issues today, and although they are connected in the sense that as we visited around the country we discovered that the readjustment counseling centers were a good point of entry for people to be referred to the so-called combat units, we did see a great deal of interest in the issue of post-traumatic-stress disorder arising first in the readjustment counseling centers and then throughout the VA system. There is a great deal of concern among the veterans at large about this issue, about the research on the issue, about the number of centers that focus on it.

I was surprised at the comments in your formal testimony, Dr. Custis, about general support for the idea and the concept but not for a law to make sure that that concept gets implemented. I understand the reason for that. It is a similar kind of analogy that the VA testified against having a Women's Advisory Board within the VA because they didn't want it mandated. It is now mandated, didn't hurt anybody, and it just makes it a little bit more formal. I understand why you might have testified the way you testified, and I would like us to spend some time focused on that the legislation that has been introduced and the reasons for it.

Dr. Custis, your statement indicates that you plan to have 12 post-traumatic-stress disorder units in the near future. How many are open today and when are the others expected to open; how many beds are going to be available when all 12 units are opened?

Dr. **Custis**. If I may start and again defer to Dr. Blank, we have at the present time 10 such units. There were 11 and 1 closed for a very interesting reason just today. Some of these units——

Mr. **Edgar**. It closed just today?

Dr. **Custis**. Yes, sir. I think you are familiar with the circumstances.

Mr. **Edgar**. I am familiar with it.

Dr. **Custis**. The fact that that unit closed today I think is illustrative of one of the problems that is not confined to the Cleveland unit. There are other units that are inadequately staffed. We would very much like to see some restraint on local initiative to open units unless they can, indeed, properly man them.

Manpower is a problem across the whole health care system, as I am sure you know, Mr. Chairman. We are, in general, marginally staffed, and especially so in our psychiatric units. We have every intention of receiving and giving consideration to proposals for these units in any hospital that feels they have the local talent and the ability to initiate such a program.

It is not the only methodology for treatment, however.

Mr. **Edgar**. Dr. Custis, if I might interrupt you at that point, I don't think any of us from the committee point of view in introducing the legislation were suggesting that we ought to have established *x*-number of these centers and believe it is the only methodology. I think our analysis, going across the system, is that there are other treatment modes and treatment models, and we are supportive of your comment that this is just one piece of a larger puzzle that we're trying to solve. I appreciate that. I just wanted you to know that it is not our intenton to think that once we establish these centers in a more formal basis that we intend that that's the only way to deal with this issue.

Dr. **Custis**. We particularly appreciated that as we heard your opening statement, Mr. Chairman.

Dr. **Brown**. Mr. Chairman, we currently have 273 beds in these PTSD units that you're referring to. As you mentioned, we have 10 units today. Two more should be in existence before the end of the fiscal year. We anticipate that one in Brecksville will open in approximately July.

Mr. **Edgar**. Thank you.

Dr. Custis, who is in charge of planning efforts regarding the establishment of the PTSD units?

Dr. **Custis**. The Mental Health Service and Professional Affairs.

Mr. **Edgar**. Is there a lead person?

Dr. **Brown**. John Lipkin is the individual who has that responsibility.

Dr. **Custis**. Dr. Lipkin is present in the audience, Mr. Chairman.

Mr. **Edgar**. Dr. Custis, I understand that Dr. John Lipkin, Associate Director for Mental Health and Behavioral Science Services, has been active in providing leadership and assistance to the VA medical centers interested in establishing Vietnam veteran inpatient programs, and I appreciate him joining the panel.

What guidance have you given Dr. Lipkin concerning these programs—and maybe I should ask this of Dr. Lipkin—have you visited all the locations where such units have been established?

First, Dr. Custis, have you given Dr. Lipkin any particular guidance in his analysis there?

Dr. **Custis**. Not only does the program director have guidance, but also that guidance has also been incorporated into the MEDIPP guidance. The criteria, however, are still under development, and I would defer to Dr. Lipkin for that information.

Dr. **Lipkin**. In answer to your question, I have not yet been able to visit all of the sites but I am in the process of doing so.

Mr. **Edgar**. What has been your experience, Dr. Lipkin, about the units? What kinds of things have you discovered and what kinds of questions should we be asking our next panel?

Dr. **Lipkin**. I think, as Dr. Custis mentioned, staffing is an important issue. Another issue is having the necessary local talent to put together a program. Programs vary a great deal by location, and by the available talent at a medical center or in the community. These factors make a large difference in how easily an effective unit can be put together.

Mr. **Edgar**. Let me ask another specific question relating to that. Is there any rule of thumb noting that there needs to be flexibility in the establishment of these programs? Is there any rule of thumb as to how many staff per patient ought to exist to make for adequate care and treatment?

Dr. **Lipkin**. We have tentative guidelines. These must agree with local staffing patterns, given that these units have been funded locally. I think ideally there has to be enough professional staff to do a thorough job. I am reluctant to put numbers to that. It depends on the size of the patient population that they're going to serve and the kind of program they're going to deliver.

Dr. **Brown**. Dr. Lipkin is being very hesitant because what he has recommended has not been approved as yet, but his recommendation is that the staff ratio be 1-to-1.

Mr. **Edgar**. Dr. Custis, we authorized an additional $15 million in our report to the Committee on the budget for PTSD units authorized by H.R. 4833. In your opinion, would $15 million cover the cost of the 15 units?

Dr. **Custis**. We have a paper in response to this that we would like to provide for the record. We estimate that the cost of this is approximately $1 million per unit. The breakdown on that is in writing.

Dr. Blank, do you want to add to that?

Dr. **Brown**. We do have a paper on this.

Mr. **Edgar**. So if we have 16 units, we will need $16 million; if we have 10 units, we will need $10 million.

Dr. **Brown**. It is more than that.

Dr. **Lipkin**. It's closer to $1.2 million per unit, Dr. Brown.

Mr. **Edgar**. How much are we currently expending per unit? Let's take the eight best units—what is their cost?

Dr. **Lipkin**. I don't think we can answer that today.

Mr. **Edgar**. Could you provide that for the record?

Dr. **Custis**. I'm sure you will find there is quite a variance.

Mr. **Edgar**. It would be helpful for us to see the variance. Why don't we just list out the 1983 units that were established and how much we expended on each of those and provide that for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

COST ESTIMATE

Type	Salary	FTEE	Cost
Staffing pattern per 30-bed unit:			
Psychiatrist	$80,000	2	$160,00
Psychologist	40,972	2	81,944
Social worker	28,750	2	57,500
Nurses	25,159	15	377,385
Nursing assistants	15,681	9	141,129
RMS	23,761	2	47,522
Vocational rehab	23,761	1	23,761
Educational specialist	40,972	2	81,944
Research coordinator	40,972	1	40,972
Total			1,012,157
Plus 1 M.D.; Ph.D.; MSW; RN, or a total of 4 FTEE outpatient therapists and secretarial support to provide screening, followup care, etc.:			
Psychiatrist	80,000	1	80,000
Psychologist	40,972	1	40,972
Social worker	28,750	1	28,750
Nurse	25,159	1	25,159
Secretary	14,015	1	14,015
Total			188,896
Inpatient staffing			1,012,157

COST ESTIMATE—Continued

Type	Salary	FTEE	Cost
Outpatient followup staffing			188,896
Total			1,201,053

Note.—For a new program, additional costs would include dietetics support, pharmacy support, lab support, etc. For 15 new units, 615 FTEE and $18,015,795 are required for clinical services. This includes special support to research and educational development at each PTSD center. Funds for educational programming are not included in these estimates. It is anticipated that an additional $1,810,000 would be required to fully implement a training program systemwide to meet the provisions outlined in this legislation.

The costs for research would depend upon the scope and design of each independent investigator's proposed project.

Mr. EDGAR. Dr. Custis, it is my understanding that an unfortunate incident occurred in one of the PTSD units at the Brecksville Division in the Cleveland VA Medical Center within the last week, and I understand from your statement today that that unit has now been closed.

Would you, in brief summary, tell us what happened and who is presently in charge, or who was in charge, of the unit?

Dr. CUSTIS. May I defer to Dr. Brown.

Dr. BROWN. The unit was opened in January of this year. I don't remember the name of the person who was selected to head it up, but he is a minister who is also a counseling psychologist.

The staff had considerable difficulty with the unit and, as a matter of fact, the director consulted with Dr. Jack Smith, who is on the next panel, on this matter. We were interested in obtaining the services of Dr. Jack Smith to head up a new unit. With such consultation, the director decided that, because of the turmoil within the unit, it had to be closed.

The incident that precipitated this closing was two patients who became violent, took a hostage captive, one of the nursing personnel, and barricaded themselves in rooms. We had to not only call the station police but also asked the local police to come in and assist us. Ultimately it turned out all right. We talked them out of the rooms. They had to be restrained, but they have been removed now.

Mr. EDGAR. Dr. Brown, I realize that this situation is very serious. I think you made the appropriate move in closing it for a time and hopefully reopening it under new creative leadership.

I do have a question. We had the head of the in-house veterans security force here and I was frankly very impressed with their dedication and their commitment. I wonder why, given the trauma of this situation, why the local police had to be called in. Could it not have been handled by the internal security? As I understand it, there were no indications of guns in this case——

Dr. BROWN. That's correct.

Mr. EDGAR. I wonder about whether or not there was some specialized police from the outside called in that may have traumatized the situation even further. I understand and I am real cautious in even raising this issue because decisions have to be made closely in the field and immediately, and fortunately it was resolved without too much trauma or additional injury. I commend you and the staff for doing that.

But I just want for our record to know why the decision was made to call in the outside.

Dr. **Brown**. Mr. Chairman, I always question this because I think this sort of thing should, with rare exception, be handled in-house. However, I have looked into it this morning and talked to the people from the scene. They do have a crisis team in-house of nursing personnel and others who were called to the scene. They were all very frightened of these two individuals. Apparently they are very large, muscular individuals who are highly skilled in martial arts and had hurt people before. Everyone was frightened of them, frankly, and the decision was made to call in the police.

I think it is a mistake for us to judge them on that. Unless you're on the scene in a situation like that, I don't think you can judge what they have done.

Mr. **Edgar**. In light of this situation, will there be some effort to train our police forces in-house, in the areas where we have a special concern like this, or will we continue the present policy?

Dr. **Brown**. It is very important for every one of our institutions who treat a large number of severely disturbed individuals to have crisis teams prepared and trained. My understanding is that Brecksville does have such a team and they are well trained. Is that accurate, John?

Dr. **Lipkin**. Yes, sir.

Mr. **Edgar**. Thank you. Again, I want to make sure it is clear for the record that we're not second-guessing anyone. We are very pleased with the way in which this particular serious incident was handled. We hope that this kind of situation will be minimized in the future. We understand this level of disturbance is even more of a reason why we should recognize that this particular war and time period does create post-traumatic-stress which may, in fact, be a deeper psychological stress than we had at first thought, and there are incidents at this end of the extreme that are very violent and we have to recognize as the reason we're in the business that we're in.

A final question. Dr. Custis, your prepared statement indicates the VA has broad authority to sponsor research and education in post-traumatic-stress disorder. In addition to the Vietnam veterans needs assessment study mandated by Public Law 98-160, what clinical research into PTSD has or is the VA conducting, and what formal education programs have you made available to the clinicians? Can you identify how much money has been spent on these research and education efforts?

Dr. **Custis**. Mr. Chairman, we are prepared to submit answers to both of those questions in writing.[1] Dr. Brown and Dr. Hollis Boren, the ACMD for Research, are here to address it verbally, however.

Dr. **Brown**. Currently we have 8 research programs that are centrally funded and 22 programs that are funded by local funds. I will rely upon Dr. Boren to give us the dollar amount of that, and also to elaborate on the training question.

Dr. **Boren**. Thank you very much for the opportunity to answer this because we are very sensitive to how important this problem is and how difficult research in this area is.

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[1] See p. 71.

We have relatively few projects. Knowing how important it is, it is a tragedy we do not have more projects. As Dr. Brown has stated, we have only some six projects that are centrally funded with an annual funding this year of $360,000. There are locally funded some 22 projects for $76,000.

We have been enough concerned about the small numbers and the track record of our proposals that we have done something we have never done before. We have taken the initiative to outline the guidelines for the preparation of proposals in this area to be circulated, addressing the questions of diagnostic criteria, and the selection of patients, and controls, to aid the investigators to prepare proposals.

Second, we have a workshop scheduled for this September to help train investigators, and third, we have constituted a panel of consultants to help investigators do research in the area of post-traumatic-stress disorder.

Mr. **Edgar**. Thank you.

Just one final question to you. In light of the research that we have done, is there a possibility—and Dr. Lipkin may want to respond to this, too—to put some of the evidence, the materials of what we have learned, into some readable form for the general public? I am interested in the concept of some journal articles that would, in a generalized way, with some specific data to back it up, explain what we're talking about, because when you talk to somebody about post-traumatic-stress disorder, unless they follow it in the field, their eyes glass over and they say "What are you talking about?"

Do we have enough feel for the problem to be able to generate some articles, some oped pieces, some Congressional Record statements, that could, in a clear way, demonstrate what the VA has done in making a contribution to the field of psychiatric medicine in this area?

Dr. **Lipkin**. In terms of professional articles, Mr. Chairman, VA people have taken the lead in the professional literature over the past couple of years. Dr. Blank and some of your panelists and others have regularly published articles which are widely read. In addition, they and I and others have put together training programs at the American Psychological Association, the American Psychiatric Association and other kinds of professional training sites. So in the professional realm, there is a great deal that is coming out, and I think there is going to be an increasing flood of this kind of literature.

There are also a number of videotape presentations like the one that is being shown in the House this week by Mr. Gusman and his colleagues. In addition, Dr. Blank, through the Readjustment Counseling Service has some training tapes in production. A number of those that are beginning to circulate.

Mr. **Edgar**. I think the tape that we're showing on the House Information Service is what I'm trying to get at. It is much more of a lay person's view of the problem. I commend the professionals in the field. I have looked at some of the articles and we have talked to people about some of the materials in those articles. The problem is, people who are not gifted in the language of professionals often either misunderstand the articles or have just a vague view of what we're talking about.

I think maybe one of the goals for all of us over the next year, given the fact that we have now some hard experience and we're gaining some more and moving in that direction, whether you do it or whether we mandate that you do it in the legislation, I would just like to see us figure out some ways to take that taped material and put it in other forms and to make sure that TV and radio people and print media people, as they report on these issues in the future, have some lay person's guidance to the problem so that they don't misstate it.

I can imagine that, in this incident that we had over the weekend, some reporters coming in quickly to do an analysis of that story, if they heard the word—it's like the word "infrastructure" in public works lingo; people's eyes glass over. We have got to figure out a way to interpret it so that the general public understands why it is important that we move in this area.

Dr. BLANK. Mr. Chairman, I would like to mention that, with specific regard to the general public and conveying this problem to the layman, vet center staffs have been very active in this area and will continue to be through community education, appearances, and talks and that sort of thing. In addition, it is our hope that somehow our vet center staff will be able to carve out time for more writing, especially in the next year.

Finally, I think it should be mentioned that the Regional Medical Education Center of the Veterans' Administration have been particularly active in the last 18 months in training professionals. This is not with reference to the lay public but to professionals.

Mr. EDGAR. Thank you.

Let me yield to my colleagues, and I apologize for taking as much time as I did, but I wanted to cover those areas.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I will try to partially at least make up for your additional time.

Dr. Custis, you support, and the Veterans' Administration supports the objectives embodied in H.R. 4833, which basically tells me that you feel that the concept of the combat unit treatment centers is a good idea, that it's a good concept, right?

Dr. CUSTIS. Yes, sir.

Mr. BILIRAKIS. Could the Veterans' Administration use an additional $15 million to be allocated to this concept?

Dr. CUSTIS. I'm sorry, Mr. Congressman. Would you repeat that?

Mr. BILIRAKIS. Well, could the VA use an additional $15 million to be allocated toward this concept?

Dr. CUSTIS. You mean the several programs referenced in the bill?

Mr. BILIRAKIS. I mean the combat unit treatment concept in general.

Dr. CUSTIS. Yes, sir.

Mr. BILIRAKIS. So your fault with the bill is basically not with the $15 million but the fact that you're told how to use it; is that correct?

Mr. IBSON. If I might interject, sir, the bill proposes an amendment to chapter 17 of title 38 under which the administrator already has very broad authority. We are concerned that the bill, to some extent, may restrict that authority.

Just to give you an example, the eligibility provisions of the bill may well narrow the authority that the VA right now has to place veterans into PTSD units. For example, a veteran from Granada who was not also a veteran of Vietnam might well not be eligible under the bill for placement in such a unit. There are a number of——

Mr. **Edgar**. Would the gentleman yield?

Mr. **Bilirakis**. Yes.

Mr. **Edgar**. It sounds like your answer is a legalese answer. Dr. Custis already indicated his willingness to work with us to make sure that the unintended intention of the language can be clarified to not do that kind of thing, of saying a traumatized Granadian veteran or someone who stood next to the building as it blew up in Beirut would not qualify for action. We will go through a markup session where that language can be changed.

I think it is important to focus in on Mr. Bilirakis' question, and that is, if we work out those particular legalese questions and mandate that 15 centers be set up, and give the authority, "where's the beef?" [Laughter.] No; where's the question? Isn't it just a difference of opinion as to whether or not Harry Walters should have that authority, or whether Congress should mandate that authority on Harry Walters?

Mr. **Ibson**. I would apologize for my legalese, sir, and express our willingness to work with you. I would hope that we could harmonize the concerns.

Mr. **Bilirakis**. I would ask another question, if the gentleman would yield back.

When you were working up your bill, Mr. Chairman, which concept I certainly agree with, did you work with the Veterans' Administration and get their input and their suggestions so that we could have a bill that apparently the Veterans' Administration would support? We don't want VA to look like the bad guys as far as the veterans' organizations are concerned by opposing something that is good for the veteran. I ask that question because that's where the "beef" is. I used to say "meat" but now I suppose we have to change it to "beef." The bottom line is what can we do for the veterans. We are all cost conscious, and we have got to be, but at the same time we are all concerned about the veterans.

So I ask that question in general of everybody.

Mr. **Edgar**. If the gentleman would yield, there are three parties involved—one is the VA, one is Congress, and one is OMB. I think the question at this point is clearance from the Office of Management and Budget for any piece of legislation, even if it was agreed to word-for-word, at a staff level by the VA.

The answer to your specific question is yes, we worked with, talked with, and listened to suggestions and recommendations at a staff level and went to our own legalese professionals and put it in language that we thought would work. There are some minor concerns, but in general I think the staff level of the VA, who understands the post-traumatic-stress disorders, and the staff of the committee are in concurrence, that if, in fact, you move on the legislation, this is about what you want. The question is OMB hasn't given clearance for that legislation.

Mr. **Bilirakis**. But is that the reason why the Veterans' Administration officially believes there is no need to enact this legislation?

Mr. **Edgar**. Let me say, for them, yes. They can't answer that question. Let the record show there is a nodding of heads. [Laughter.]

Mr. **Bilirakis**. Thank you, Mr. Chairman.

Mr. **Edgar**. Mr. Daschle.

Mr. **Daschle**. Thank you, Mr. Chairman.

I'm curious as to what the real scope of the problem is. One of the witnesses who will come after you will state that approximately 10 percent of the veterans who currently seek assistance from vet centers are to be determined in need of some psychiatric inpatient care.

Now, if the average stay of one of those people is 90 days, and we have 223 beds for that purpose now, that would mean that we probably have about enough capacity to serve roughly 1,000 patients, which would seem to me, if those figures are right, we're falling 9,000 beds short, at least 9,000 beds short, of what we need. If one bed will serve four patients in a year, then we are at least 2,000 to 3,000 beds short.

Do you see it as that severe a problem in terms of shortage of beds right now, Dr. Custis?

Dr. **Custis**. I think you're getting into an area that is awfully hard to pass accurate judgment on. I can respond in this fashion: We have, at any given time, approximately 15,000 empty beds in our hospital system. Now, they are not always where you might most be able to use them, and I am not aware that we turn away any patients in need of psychiatric care. So from the standpoint of bed need, I don't think we have any, over and above what is already out there.

We are, indeed, turning away patient applicants, but they are not in the category of the Vietnam veteran or the psychiatric patient. We at the present time know, from a recent survey that we did, that the non-service-connected medical/surgical type patient is being turned away from access to care at the rate of 20,000 a month.

Mr. **Daschle**. You said we had 223 beds——

Dr. **Brown**. It's 273.

Mr. **Daschle**. Excuse me, 273 beds.

How do you differentiate between an inpatient psychiatric bed and a medical bed? I mean, do you then not have 15,000 beds if you used them as such?

Dr. **Custis**. It has much more to do with staffing.

Mr. **Daschle**. So it isn't that you have the beds, per se; it is that you probably don't have the kind of staffing to ensure that those beds are utilized.

Dr. **Custis**. We do not have adequate staffing in any service in the system, literally.

Mr. **Daschle**. Well, let me rephrase my question, then.

Let's assume we do have 10,000 veterans who may need help, if this figure is accurate; we have 273 beds which can be staffed with psychiatric personnel; are we then falling short some several thousands of beds which can be served with psychiatric staff for those in need?

Dr. Custis. I really think, Mr. Daschle, that's a leading question. I would come back to the fact, as I know it, that we are not turning away patients who come to us for care.

Now, you can talk about——

Mr. Daschle. You're avoiding the question. There's a difference between turning them away—I mean, if you want to bring them in and put them in a bed and leave them there, that's one thing. If you want to bring them in and give them the kind of psychiatric attention that they need, that is something altogether different. It is one thing to house one, and it's another thing to serve one, to treat one.

It seems to me that we are in dire need of additional beds with psychiatric staff to serve those beds. What I am asking is your appreciation of how serious that need is. We're being told here that we have a 10,000 patient potential; you're telling me we have 273 beds. Now, that seems to me like an incredible disparity. All I want you to do is to address what seems to me to be a very serious problem with regard to a shortage of beds with appropriate staff.

Dr. Custis. The 273 are units already established. These are dedicated units. In addition there are many of our hospitals that are placing these patients in their psychiatric sections. Those who favor the units much prefer not mixing patients like that. But the 273 are the 10 units presently dedicated to PTSD care.

Dr. Lipkin would like to respond to your question, too.

Dr. Lipkin. The numbers in terms of how many veterans with post-traumatic-stress disorder need hospitalization are very broad in range. Last year we discharged 4,000 patients from VA medical centers with a diagnosis of post-traumatic-stress disorder. In addition, some of those patients referred from vet centers to VA medical centers are referred to alcohol treatment, for substance abuse or depression, for schizophrenia, or other conditions which are properly treated in existing units and in existing medical centers, so that the size of the deficit, if you will, is not nearly as great as you imply. It is something we are working on and defining further through the MEDIPP planning process.

Mr. Daschle. I'm not going to belabor the issue. I know I'm out of time. I will thank the gentlemen for their comments.

Mr. Edgar. Thank you.

Is there any final comment that anyone on the panel wants to make to clarify one of their statements or to give a summary statement?

I want to thank all of you for testifying today and we appreciate your presence here.

Our next panel is Dr. Steven Silver, Mr. Fred Gusman, Dr. Arthur Arnold, and Dr. John Smith. If they would please come forward at this time, it would be very helpful.

As you are coming forward, I thank you for your presence here today. Some of you we met in our tours and efforts around the country to understand the program. We realize that it has taken a little longer this morning, but I think we did get some very important testimony on this issue as well as readjustment counseling centers.

Dr. Silver, perhaps we can begin with you. You are the staff psychologist for the Post-Traumatic-Stress Disorder Program at the VA Medical Center in Coatsville, PA. Let me say to all of you gentlemen that the full text of your statements will be made a part of the record, if you choose to summarize and target in on some of the issues that we have raised, or other issues that you would like to raise.

Dr. Silver, we will begin with you.

STATEMENTS OF STEVEN M. SILVER, STAFF PSYCHOLOGIST, INPATIENT POST-TRAUMATIC-STRESS DISORDER PROGRAM, VA MEDICAL CENTER, COATSVILLE, PA; FRED D. GUSMAN, VIETNAM VETERANS TREATMENT UNIT, VA MEDICAL CENTER, PALO ALTO, CA; ARTHUR L. ARNOLD, M.D., CHIEF OF PSYCHIATRY, VA MEDICAL CENTER, PHOENIX, AZ; AND JOHN RUSSELL SMITH, INCOMING DIRECTOR, CENTER FOR TRAUMA RECOVERY, VA MEDICAL CENTER, BRECKSVILLE DIVISION, CLEVELAND, OH

Mr. Silver. Thank you, sir.

Considering that our statements will be put into the record, I won't go through mine at this time, except to extract a couple of major points that I would like to make.

In particular, I think one of the main points we would like to raise is the necessity of including the families of Vietnam war veterans who have post-traumatic-stress disorder as potential candidates for counseling services. My experience over the past 13 years in working with Vietnam veterans and their families, plus a national research study I did, plus the research and clinical experience of other people, convinces me that the impact of this particular disorder is extremely widespread, and whatever the number of Vietnam veterans we might come up with who have it, I think we are also talking about possibly doubling or tripling the number of people who are actually affected by it due to the spread through the family.

Another point we would like to make is I have heard talk today about the usefulness of conducting research and education services, and we fully support that. We are heavily involved in it ourselves. But as far as research in post-traumatic-stress disorders is concerned, I have one note of caution. At the present time the post-traumatic-stress disorder program at Coatsville would be unable to carry out any of the most passive kind of research. The reason for this is that our staff is stretched extremely thin in providing services. To take any kind of research effort would run the risk of deteriorating therapeutic services. Caution, therefore, would have to be used regarding the imposing of research requirements unless there was sufficient trained staff to reasonably handle it.

Staffing is, of course, the critical issue. Our program has a psychiatrist, a psychologist, and a clinical nurse specialist on full-time status. I might point out that when we began we only had a psychologist on full-time status; our psychiatrist was halftime, and our clinical nurse specialist covered two other programs. Our social worker and our nursing staff still cover at least one other program and frequently more. We have beds for 13 men and 2 women in our

4-month program. Apparently because of our reputation, we are receiving referrals from New England, New York, New Jersey, Delaware, Maryland, West Virginia, Ohio, Virginia, the District of Columbia, and, of course, from throughout Pennsylvania. Our waiting list is more than 8 months long. It says something about our veterans that so many of them are willing to endure this wait, though I am deeply concerned about the fate of those who drop off and out.

Again, referring to staff, my coworkers stressed repeatedly to me as I was preparing to come down here today the necessity of not simply plugging in more numbers of staff but adequately trained and prepared and motivated staff. In the course of our outreach education efforts to professional audiences as well as community audiences, we are still finding, somewhat surprisingly, there is ignorance as to what posttraumatic stress disorder is, how it is treated, and how it relates to the Vietnam war experience. It is reasonable that those who staff future programs be provided with the best training possible. Obviously, motivation cannot be trained into someone, but it is possible to sensitize professional staff to the Vietnam veteran experience. We would urge, in the strongest possible terms, that this be done.

We are also particularly concerned about populations that have not been reached, that because of their isolation and disadvantaged positions, are not being touched by current services. Particular populations needing attention would include American Indians, Hispanic, and something we consider particularly important, women Vietnam war veterans.

A more general comment I would make is that the development of inpatient PTSD programs is not a simple procedure. Not only will competent, sensitive, and motivated staff have to be recruited and trained, there are other issues to deal with as well. Patient selection, diagnosing, and followup are extremely important. Programs should not be a dumping ground either for staff or patients and careful monitoring of their development should be an ongoing concern.

I would be happy to answer any questions you might have.

[The statement of Steven M. Silver appears at p. 127.]

Mr. EDGAR. Dr. Silver, on page 3 of your testimony, am I clear in reading the statement that says "Our waiting list is more than 8 months long"?

Mr. SILVER. Yes, sir. As of yesterday afternoon, when I left Coatsville, mathematically our waiting list was approximately 8 months, 2 weeks long.

Mr. EDGAR. What happens to a veteran who is on that waiting list? Are other services provided?

Mr. SILVER. Typically what happens is that the veteran, once evaluated by us and placed on our waiting list, then goes into, in large measure, what resembles a limbo period. Whatever ward they happen to be on, be it in our hospital or in another hospital, the basic orientation is toward providing them with support to remain in the hospital setting until such time as they can transfer to us. Not a whole lot in the way of treatment is begun, in part because of the concern about that process being interrupted by being transferred over to us.

Mr. **Edgar**. Thank you very much. I have other questions for you after we hear from the rest of the panelists.

Mr. Gusman.

STATEMENT OF FRED D. GUSMAN

Mr. **Gusman**. Mr. Chairman and committee members, before I proceed with my testimony I would like to share with you a personal feeling that I bring with me today from California. I find myself coming before you today experiencing two conflicting emotions.

The first is that it is personally disturbing that 10 years post-Vietnam this country is still struggling with resolving psychiatric problems that the Vietnam veteran has incurred by serving this country honorably. The second is the honor you have bestowed on me to share my personal and professional expertise on the treatment of PTSD in an inpatient psychiatric setting.

Mr. Chairman and members of the committee, in 1977 a multidisciplinary task force conducted a survey of veterans hospitalized at the Menlo Park Division of the Palo Alto VA Medical Center. That survey found that Vietnam veterans desired psychiatric services more specific to their special problems. In response, the task force was given strong and continuing administrative support for the implementation of such a special program.

Consequently, the Vietnam Veterans Treatment Unit was opened in 1978. In 1981, the program was expanded to its present 90-bed capacity and has generally maintained a full census ever since.

The Vietnam Veterans Treatment Unit is an inpatient psychiatric treatment program specifically designed to treat combat-related post-traumatic-stress disorder, PTSD. The patients treated cover a wide range of racial, ethnic, and socioeconomic groups. They are residents of the northern California catchment area or of more distant places upon special request and approval. Fifty to seventy percent have a history of life-threatening depression. All are in acute distress in addition to manifesting varying degrees of PTSD symptomatology.

The mission is first, to relieve acute psychological distress, second, to restore the veteran to a maximal level of functioning within a minimal period of hospital stay, and third, to reintegrate the veteran into the community.

The identity as a Vietnam veterans program underscores the positive identity of the Vietnam veteran and deemphasizes potential further stigmatization as a mental patient or behavioral deviant. In the program the veteran is encouraged to reexamine war experiences in the context of any conflicted decisions made there or since.

The turmoil in our country during the Vietnam war caused many of the combatants to feel that their heroism was meaningless and their Nation uncaring. Defining the program as a Vietnam veterans center is a direct message that their contributions are valued and their suffering legitimate.

The Vietnam Veterans Treatment Unit is a modified therapeutic community emphasizing self-help, peer support, and peer pressure principles within a grounded base of traditional psychotherapeutic modalities. The treatment helps the veteran "debrief" from the military experience and reconnect with the civilial world. Psychiatric interventions are highly specialized in the diagnosis and treatment of this psychiatrically ill population.

The program employs a wide array of specific psychotherapeutic techniques, including transactional analysis, Gestalt, and hypnosis. Additionally, social work knowledge and skills are the basis for the program's planned community in which patients are assigned or achieve roles and functions which confer status, self-esteem and social usefulness. The program fosters a Vietnam veteran subculture so that patients can develop cohesive support both within the medical center and the outside community. Group approaches are emphasized because a major goal of the program is to foster the development of trust among members of the Vietnam veteran peer group.

Treatment is divided into three phases. Each phase requires 45 days. Many therapeutic issues, however, are addressed throughout the program and are not phased. All phases deal with anger, interpersonal intimacy, minority concerns, sexual functioning, employment, and financial concerns.

In phase one, newly admitted patients seek the resolution of the acute crisis which may have brought them into therapy. There is a considerable amount of emotional catharsis as trust is built up between the veteran, the veteran's peer group, and the staff. Matters outside the program are cleaned up which might interfere with the veteran's commitment to personal therapeutic work within the program.

Treatment starts where we find the patient. This often means dealing with an angry, depressed veteran who expects less than an even break and who is still living out the Vietnam trauma. In this group, "history of Vietnam," the veteran will begin to test the factual validity of some personal attitudes. In "Vietnam focus," we deal directly with the individual's own personal Vietnam. The veteran may experience an abreaction of emotion whose force and drama cannot be adequately described. Emotions come pouring out like pus from a lanced boil. These emotions are not secondary effects—feelings about the past—but primary effects, those experienced during the event itself. Such an abreaction is indistinguishable from a flashback or a spontaneously induced trance state. If the anxiety is managed effectively, the veteran is both "there" and "here." This therapeutic encounter permits the veteran to process the trauma and to reexperience a sense of belonging which may have been lost in the jungle. This acute phase of therapy usually takes less than several months, sometimes only weeks. It is the beginning of the process of "coming home." The veteran's Vietnam may become a source of inspiration and of renewed commitment to values and meaningfulness.

Phase two patients are typically out of crisis and settled into the program. Patients with thought disorders and other psychiatric conditions requiring psychoactive medications have been appropriately diagnosed and medicated. Patients for whom combat-related experiences are not major factors in their suffering will have been referred to other treatment centers as indicated. During this phase neurotic projections of responsibility are discarded, not because they are totally invalid but because they prevent personal growth. Coping skills are learned and, by the end of the phase, patients have developed solutions or alternatives to problems which have been delineated and will have mapped out plans for reintegration into society's mainstream.

Phase three is devoted to psychosocial rehabilitation. Housing, income, relationships, employment, and educational opportunities are pursued. This is a hospital-to-community transitional phase for trying out the skills learned in the program. Veterans in this phase of the program serve as counselors in a crippled children's camp, volunteer in Big Brothers of America, and group workers in a local senior center. The patients also participate in the combat veteran choir group which has performed throughout California and in Washington, DC. The community work done by the veterans and the national acclaim earned by the program both serve as therapeutic adjuncts to the building of a positive self-image.

From its inception the program has received active encouragement at the medical center level, the regional level, and at the central office level. At the medical center level, clinical and administrative guidance and support have been provided by the Director, Chief of Staff of the Menlo Park Division, Psychiatry Service and Social Work Service. This sanction has resulted in provision of staff space and furnishings.

The Regional Director for region 6, Mr. Dan Cooney, has met with me periodically and we are working together to develop a Vietnam veteran regional demonstraton project. This project would include clinical care and teaching and research in the area of PTSD in the western region.

At the central office level, Dr. John Lipkin, Deputy Director, Psychiatric Service, has provided consultation and direction to the program director and has visited with the patients and staff at the Menlo Park, CA, VA Medical Center. Mr. John Fulton, Director of Social Work Service, VA Central Office, has provided guidance to the program director during several meetings both in Washington, DC, and in California.

Mr. Chairman, this completes my statement.

[The statement of Fred D. Gusman appears at p. 131.]

Mr. Edgar. Thank you very much. I have additional questions to ask of you, but just one question about your testimony.

On the first page of your testimony you have the words "designed to treat combat-related post-traumatic-stress disorder" at the bottom of the page, in definition of what the Vietnam treatment units are supposed to do.

I wonder if you could comment just on the word "combat". Some of the service organizations will be testifying later that perhaps that definition ought to be broadened because of the level of stress that may be related to service in a particular part of the world that may not just be combat related.

Mr. Silver. Yes, sir. At our particular program we serve all Vietnam veterans who were in-country. Now, combat can vary. We might perceive combat as being the cook who goes out in the field one time. We don't distinguish it by how many times he was in the field or his job, but rather that he was in-country.

Mr. **Edgar**. You don't see any need to broaden the definition of "combat"?

Mr. **Silver**. Well, it might be an inappropriate term. I think that what we found, we have seen over 2,500 Vietnam veterans who served in-country, and we find that the man who served on the ship off the coast can be as equally traumatized as somebody who was in the field for 13 months.

Mr. **Edgar**. Thank you.

Dr. Arthur Arnold, chief of psychiatry, VA Medical Center, Phoenix, AZ.

STATEMENT OF DR. ARTHUR L. ARNOLD

Dr. **Arnold**. Thank you, Mr. Chairman.

Before I begin, I would like to point out, for the record at least, that my colleagues on this panel are all Vietnam combat veterans. In addition to that, they subsequently established themselves nationally as authorities in the field of PTSD and have made a tremendous contribution, not only to other professionals but certainly to Vietnam veterans. I am personally very honored to be at this panel with them.

As you mentioned, I am chief of psychiatry at the present time at the Phoenix VA Medical Center and previously I was the chief of psychiatry at Bay Pines, where I established the Vietnam Veterans Combat Unit in 1981. I feel that that is by far the most satisfying professional experience of my entire time in psychiatry.

In addition to that, I have been involved in organizing and conducting professional education, diagnosis and treatment of PTSD. I might say that on almost every occasion participation in these programs, particularly those organized by the regional medical education centers, has been very much oversubscribed. There is a high level of enthusiasm and pressure for attendance and an interest in learning in this field.

As a member of the VA-sponsored field task force, and also an officer in the National Association of VA Chiefs of Psychiatry, I have been working on the problems of diagnosis-related groups as they may impact upon the allocation of resources and dedicated units treating PTSD and I share with Dr. Smith, who is on this panel, the honor of being on the Advisory Committee on Readjustment Problems of Vietnam Veterans.

At Bay Pines, in 1979 and 1980, it was quite clear that the condition that was present in most Vietnam combat veterans who were treated on my acute psychiatry wards had the symptoms of PTSD. But I was also aware, in reviewing their medical records and discussing their cases, that this was frequently not adequately recognized or diagnosed and certainly not treated appropriately. It was a common thing to find that there was an antagonism between the veterans and the clinical staff, arising largely out of this misunderstanding and lack of understanding of each other. In 1981, 20 beds, which was half of an acute psychiatry ward, was designated for Vietnam combat veterans with PTSD. The staff were voluntarily reassigned from other treatment teams. There were no additional staff.

The initial program was primarily individual and group psychotherapy which was to bring out and deal with the specific combat experiences that had so traumatized these men, but they still produced profound guilt, grief, anxiety, alienation and rage after more than 10 years.

We added an outpatient treatment team to this program, and from the start we worked very closely with the vet center staff who shared treatment roles with our unit. Gradually, as we saw the need for this, we added counseling groups for wives and girl friends of the veterans. We included alcoholism groups, we used medication very selectively, and we found that team sports and relaxation techniques were important, and we attempted to do as much as possible in vocational assessment and counseling and established a remedial basic education program for many of the veterans whose high school educations had been interrupted.

Many of the veterans improved, some of them quite dramatically, but for many of the veterans this took many months and sometimes several readmissions. We found that the most clear-cut factor contributing to the success of the program and for individual veterans was the mutual support that they provided to each other, very much like brothers. They demanded of each other and of the staff their best efforts, and they encouraged each other to show endurance, courage and the sharing of fears, grief and remorse. They sat up at night helping each other through nightmares and flashbacks, they cried together, and fortunately most of them learned to laugh again together.

This is a very intensive treatment program that is very hard on the staff. And because we had a bare minimum of the professionals that we needed, there was not time enough left to relax or to support each other and to ward off burnout. There was also no time for pursuing their own interests or furthering their own professional education in PTSD, and certainly, as the others have mentioned, no time to do research—although there was a strong interest in this. We saw that there were many other treatment modalities that we would have liked to have provided that were needed by the veterans, but there was no additional staff to provide it. There was also a great need to have the unit in a separate space, but because there wasn't enough nursing staff to cover on nights and weekends, that wasn't possible to arrange.

There was a great need for that service. It was always filled to capacity. We always had a waiting list. Literally, there were people from all over the country calling, pleading for admission, offering to come at their own expense, they were ready to fly that day. We weren't able to take any of them. Any patient that we admitted was literally admitted the same day as a discharge.

Not only could we not meet the need in our own immediate area, but since there were no other units in Florida or the Southeast United States, we needed to expand and we weren't able to do that because of the lack of additional staffing.

We also found that because their problems were so deeply ingrained after a decade of holding it all in, the treatment was a very long process. The average length of stay was about 5 months at that time. As a consequence, our turnover rate wasn't nearly the level of the acute psychiatric bed service, which had an average length of stay of less than 20 days. In other words, we were able to treat Vietnam veterans on that unit at the rate of only a sixth the number of patients per bed per year as on the acute psychiatric wards.

My major concern today is the immediate need to provide appropriate treatment using known techniques and expansion of the capacity to be responsive. Practical professional education should contribute to that end. In my view, it is important, but less urgent, that research be expanded. In other words, from my vantage point, the need is for many more comprehensive treatment units, rather than a few research and education centers with a few teaching beds. Vietnam combat veterans with PTSD have needed our help for more than a decade. Those of us who have been working on this problem consider this a pressing, here-and-now problem which is very widespread. We feel that a great many people need to work together to meet those needs.

Thank you, Mr. Chairman.

[The statement of Dr. Arthur L. Arnold appears at p. 138.]

Mr. **Edgar**. Thank you very much for your statement.

We will now move to Dr. John Smith, clinical program director appointee for the Center for Trauma Recovery Unit in Cleveland.

STATEMENT OF JOHN RUSSELL SMITH

Mr. **Smith**. Thank you, Mr. Chairman.

First of all, while it has been many years now that I have been working and I am shortly about to receive my degree, it is still "Mr.," at least for a couple more months.

As one who has been involved for many years, 14 years since I came back from Vietnam, I initially was involved in running construction companies for veterans in the initial "rap groups" in New York City. I brought together the researchers that started the legacy study that the earlier panel referred to. That took us from 1973 to 1981 to produce that report. I had the good fortune to work with the American Psychiatric Association on the diagnosis of post-traumatic stress disorder and getting it in the new diagnostic manual. I have been a consultant to the vet center program since its inception and I am very proud at this point to be joining the Veterans' Administration in the capacity of Director of the Center for Trauma Research at the VA Medical Center in Cleveland, in Brecksville.

Having reviewed the literature on combat reactions and military reactons to combat over the last 120 years as part of my research, it is very clear to me that we're engaged in a process. While we have identified very clearly the problem of post-traumatic-stress disorder in Vietnam, it is not unique. If we go back through the annals and the literature on the Civil War, on World War I, World War II, Korea, we are going to see very many numbers of Vietnam veterans. We are also beginning to see already people from Lebanon and people from Beirut and from Granada that we're going to be seeing. The problem is not confined to that, although our most dramatic focus these days is on Vietnam veterans.

It is also important to see it as a process. One of the things that is of concern to me, as I see units opening up and as I see people wanting to rush in, my reluctance in joining the Veterans' Administration and joining the program has been that I will only do it when we're going to do it right. I am not about to participate in something that is going to be half a program, is going to misuse or misrepresent what we are about to do, which is why I am proud now to be in a position of joining the program, given what is about to happen.

As slow as those changes have been, I think it is important to note the contribution that the vet center program has made, the research on Vietnam veterans, what that has done and what the Veterans' Administration and their research and their initiatives in this field have done for the whole field of post-traumatic-stress disorder. Vet center people have been involved in helping out the survivors in Coalinga. Professionals in PTSD who worked initially with Vietnam veterans were involved at Buffalo Creek in the flood, in Covington, KY, at the disaster there. I was involved last year as a result of my work with Vietnam veterans in an explosion in North Carolina, where a dormitory full of college students blew up, and we were able to go in and set up an intervention program as a result of the knowledge we gained from working with Vietnam veterans in the whole area of post-traumatic-stress.

Many of the issues that are addressed in the bill, the question of multiple services for veterans, family issues, the question of providing outpatient or followup care in addition to the inpatient services, the question of education and training, the question of basic research in PTSD and the question of outcome evaluation, how well are we doing, are all elements that we discussed and are part of the planning process for what is going to happen at that unit at Brecksville. It is our anticipation we are going to address those very questions. So I am very supportive and I applaud the efforts of the committee and the intent in this legislation for creating these.

There were a couple of specific issues that I wanted to address for the committee's consideration. As was mentioned by the earlier panel, the question of eligibility was a concern to me. I am able, in recruiting staff and interesting people to come to Cleveland to our center, in recruiting people mainly on the basis that their interest is in the broad question of post-traumatic-stress disorder. They want to take and expand the knowledge they have gained from Vietnam veterans, apply it where they are, and expand that to all of the multiple needs regarding PTSD in a medical center and in a regional area. So to confine it simply to Vietnam veterans, I would prefer to use the term "service-related post-traumatic-stress reactions," which would allow us, as we are planning to do in Cleveland, to treat POW's who are now being reevaluated in the medical centers. Where they are asking us for consultation, we would like to have the authority, as we now have the mandate to do in Cleveland, to respond and consult with other psychiatric units on the treatment of those other post-traumatic-stress disorders.

World War II and Korean veterans, we may not have them on the same units, but we want to be able to respond to those concerns. There are also people on acute psychiatric units, people on a medical unit, on a spinal cord ward, who may not be able to come to our post-traumatic-stress disorder. We want to be able to respond to that need of a post-traumatic stress in that situation for service-connected veterans. We would hate to see the legislation restrict us further from what is already our intent to address all those multiple needs with this program.

In addition, I wonder about the restriction of where the care is going to be provided, that ultimately, if there's an interest in having a geographical distribution, it might be better to say to the Veterans' Administration we would like to see this one in every medical district and not overlap. To restrict it to only 15 at that point, I think we have heard testimony about the fact that there are issues of full-time employees, there are issues of trained personnel, and I think that is a decision that in some ways the Veterans' Administration or the Chief Medical Director has to decide, in consultation with the Readjustment Counseling Service and existing units, about where we can put those. I would hate to see that too far restricted.

The question of education of health care professionals that others have addressed, and the question of research, are very important issues. As Dr. Custis, Dr. Brown, and Dr. Blank indicated in their earlier testimony, there are multiple demands on the VA health care system. PTSD is one of a number of competing interests. Congress, by allocating funds and legislation creating the vet center program, and considering legislation, is saying that this service-connected, service-related problem of post-traumatic stress should have some priority. They are putting that there, which allows us to compete for those resources.

In terms of research, there are multiple needs of the research service in the VA. Many of those are directed toward the recruitment and retention of physicians and researchers in multiple areas. Competition for those funds and having expertise in evaluating PTSD is only beginning to come on line.

When Dr. Boren was testifying this morning, he talked about the fact that they are making changes. There are some researchers currently in the VA who are among our most distinguished research on PTSD who have at times been turned down for researchers and are now getting funding from the National Institute of Mental Health rather than the VA because of the problem of the allocation of funds and the number of years they are allocated for in research. So the idea of even having modest funds that will support the multiple needs that Dr. Silver and Mr. Gusman talked about, we can't do research they were saying now unless we are given some additional support for doing it, our resources are so taxed.

In our consultations in how we were going to set up that unit in Cleveland, we very much discussed with every existing unit, all the experts in the country on PTSD, what were the existing problems. We knew about the problems of understaffing, we knew about the problems that units did not have under their own control, generally outpatient services, aftercare, and followup, that enabled them to shorten the amount of stay and enabled them to ensure, when people returned to the community, they had the kind of support networks, they had the services that you were documenting in the legislation, that are badly needed in order to do a comprehensive program. That is what we anticipate doing as a start in Cleveland in joining their ranks. But we are very much concerned that there be some indication in that legislation that some of those dollars are allocated for some of that research for us professionally. We need to document the fact that, indeed, what Mr. Gusman is doing at Menlo Park, what Steve is doing at Coatsville, indeed, works within the professional community. We need to document that.

Part of how we're putting the staff together at Brecksville is to put together a staff that can do that outcome evaluation while providing first-rate services to all of the post-traumatic needs of that medical center and that local region.

Thank you.

[The statement of John R. Smith appears at p. 142.]

Mr. **EDGAR**. Thank you.

I want to thank all of you for your statements and to indicate we appreciate the contribution you are making to helping us understand not only the program but the changes and the alterations and the improvements that we hope to make in the program.

Mr. Smith, if I could ask you a question. On page 9 of your testimony you say the following: "We need a message from Congress, not just in words of directing an already beleaguered agency to multiply its loaves and fishes; we need a message in concrete terms. We and the agency will know that PTSD treatment to complement the Readjustment Counseling Service is a priority and important when modest supplemental allocations are designated with this legislation and appropriated for PTSD treatment programs."

That is your statement?

Mr. **SMITH**. Yes, sir.

Mr. **EDGAR**. We think that that's what we were intending to do in the legislation. We hear the criticism now being made that perhaps the legislation is too restrictive in that it states 15 centers and perhaps by passing the legislation we won't say clearly that we would like to see expansion of that if and when adequate resources are provided.

We're in a little bit of a bind because we have been able to provide, through our budgetary cycle, the $15 million, and we think we can pass a bill that sets up 15 centers, which is an expansion of the existing number, and we're a little bit nervous about putting an unlimited number of centers in, not that we don't think that that would be good if we had the resources, but that we don't want the same thing to happen that happened this past weekend, in that we prematurely have a center set up with inadequate resources and perhaps with inadequate staffing that causes some trauma within the VA system.

Do you have a way in which we can send the message you want to send on the bottom of page 9 to the VA, and still keep within the guidelines?

Mr. **SMITH**. It was not clear to me when I wrote that that there was a line item for $15 million in the budget. That's what I was responding to. I was looking at passage of the legislation in the absence of any dollars or appropriations to go along with it which would seem to give a message to the VA, "multiply your loaves and fishes out of existing funds." We realize that, in fact, the programs that have been created, the one that Dr. Arnold created, the one that Fred has in Menlo Park, and the one that Steve has in Coatsville, have all come out of local resources. The one we're talking about in Brecksville was a commitment on the part of that medical center and its director to say we're going to use our resources to create this.

I agree with you, that there is an issue about trained personnel and avoiding the kinds of situations we were talking about over the weekend. I would suggest that there are ways in which hospitals and psychiatric facilities are available. We have SERP evaluations within the VA. That kind of process specifically directed, generated by Dr. Lipkin's office in conjunction with the Readjustment Counseling Service and the existing facilities, would be able to develop guidelines for periodic evaluation. We don't want to impose one model on it, but we certainly have some idea about what is effective treatment. That's part of why we want to do this evaluation, to document what is going on, what's effective, how we meet those needs, and how we know when it's getting off track. It is possible to use the existing professional resources within the Veterans' Administration to constantly monitor the success in the operation of these programs in a way that allows them some diversity and doesn't simply impose one model on the program.

Mr. Edgar. Within the comments you have just made about not imposing one model, is there a minimum number of staff that ought to be dedicated to a unit so that you have some sense that the unit at least is adequately covered with staff?

Mr. Smith. I think in earlier testimony Dr. Lipkin had mentioned the fact that he had submitted for approval a request that staffing levels be about one to one. I think it is important when we address the size of the unit. For example, when you evaluate what we are requesting and what we have asked for in terms of Cleveland from that medical center, we are asking for a staff level that is greater than one to one. That is because, when we talk about the number of beds in that unit, we are talking about in our unit creating, under our control, after care and outpatient services. So that, for example, if we have 20 beds, we're going to be servicing an additional 60 people outpatient with the same staff, because we're going to be servicing those people from the time they walk in until the time the treatment is finished. So it is important, when we look at this, not just to look at what are the number of inpatient beds. That may be adequate, that recommendation of one to one, for an inpatient service. That isn't what we generally have now. We need more than that when we are talking about providing the multiple range of services that is envisioned by this legislation.

Mr. Edgar. One other question for you, and then we'll have to adjourn for 10 minutes while I run over and vote.

I have some background in psychiatric issues, at Hodamon Hospital in Philadelphia and at the Philadelphia General Hospital when it was created, as well as some background in pastoral psychiatry. As I listen and observe and go around the country and visit these centers and see the work that they do, I am quite impressed. I think the range of services are important.

We talked about the definition of the word combat and whether or not that is necessary, and talked about its expanse to include the trauma that we face today, whether it's in Grenada or Beirut.

I am wondering whether or not, particularly in light of your statement earlier about the dormitory blowup in the Carolinas and some other things, whether we aren't seeing some trend lines in what I call the post-73 era—post-Arab oil embargo, post-Love Canal, Valley of Drums syndrome of toxic disposals sites, pressure on CO_2 buildup, acid rain, watching the film "The Day After" and the nuclear freeze movement rolling across the country and Nation—whether or not there aren't certain individuals in our society who are susceptible to a disease of trauma caused by a variety of things of contemporary society, and whether or not there aren't some people acting out in terms of marital failures, drug and alcohol dependency, prison inmates, who are really the result of being traumatized by a broken society in a variety of ways, whether or not, with the lessons we're learning in the combat units, it would in fact be helpful to other psychiatric services, or whether it's vice versa, whether we're taking the skills learned someplace else and applying it to the VA, or whether the VA is learning something new and applying it to another setting.

Just now going through that educational process, what is your best guess?

Mr. SMITH. Well, I think that you have, in fact, identified something that is very close to what we think. First of all, you talked about a post-73 phenomenon. It is somewhat ironic, in talking about post-73; it is 11 years to the day when the last American combat troops left Vietnam, so we are very much post-73 today.

As we talk about this, it is very clear to us that the more we investigate this post-traumatic-stress process, it is very clear that individuals who go through traumatic events, all individuals, go through some version of this process. We make a distinction between this normal stress recovery process and people who develop a disorder and become impaired as a result.

You asked the question about whether they are individuals who, for some reason or another, are more susceptible to this. That is one of the major current research questions. There has been a great deal of speculation through the years—in fact, a major debate—as to whether or not these are individuals who were, in fact, predisposed to breakdown whereas other people wouldn't. In efforts to document that, that has always come upon a rejection in terms of scientific results. When we tried to identify what's the factor that makes these people vulnerable, it is not one single factor. The more we examine it, the more we understand we have to look at exactly: What was the trauma, how did it affect that person, and what was the impact on them?

You're correct in identifying the fact that there are many environments in the society and many situations that are, in fact, provoking these general kinds of reactions. Our concern, and one of my pleasures in joining the Veterans' Administration, is that it looks like it is about to take the leadership role in the world in investigating these phenomena and then being in a place to share with the civilian community the things that it has learned as a result of dealing specifically with Vietnam veterans and post-traumatic stress in a service-related atmosphere.

Mr. EDGAR. The committee will be in recess for 10 minutes.

[Whereupon, the subcommittee was in recess.]

Mr. EDGAR. The subcommittee will come to order again.

We were in the midst of a discussion of your field experience. Let me turn now to Dr. Arnold for just a couple of questions.

Dr. Arnold, last year you testified before this subcommittee that some clinical staff within the VA do not accept the idea that a veteran may be suffering from PTSD. How can the VA overcome this attitude and is the VA encouraging a sympathetic attitude toward the veteran suffering from post-traumatic-stress disorder?

Dr. ARNOLD. Well, there are still a number of clinical staff who don't understand this very well, but I think the main avenue for a remedy is through education. The professional education programs that the RMEC has put on have been very well attended. There is an enthusiastic attendance. Some of the staff who have come into those sessions with doubts have more information and they are able to see PTSD more clearly and even make the diagnosis better. They may not be in a position to carry out much in the way of appropriate treatment because that is difficult to maintain on a general ward.

I think that the VA's encouragement of that so far has depended primarily upon local initiatives. The RMEC programs, for the most part, respond to local hospital requests for training programs. Those of us who have been able to put together some regional programs that have not been in response to a local hospital's request have shown that there is a high level of interest and that the attendance will be good. I think, though, that if there were some specific central guidance to the RMEC's, that this is an important field, and to not only stimulate the development of more training programs, but also to identify some VA staff who have been participating in them regularly who could serve as some resource to them and give them some guidance in putting the programs together, they would expand and be more effective.

Mr. EDGAR. You were here earlier when I asked the question about trying to take some of the technical data and the technical reports and technical studies and put it into language that the real world understands. Do any of you on the panel have suggestions on how we might encourage that? Are there some things in the works that you see that will help to get that message out as to the value of this program, as well as an understanding of the diagnosis?

Mr. SILVER. One thing I would point out is that the best vehicle I have encountered so far within the VA in terms of getting the word out has been the folks that are working in the vet centers. Recently I participated on the American Indian Working Group of RCS and they have a number of proposals underway. What they have decided is that it is possible—in fact, it was encouraged by a number of other organizations that they were cooperating with—to get just exactly that kind of word out, using various kinds of media and so forth, films and literature, postures. But that seems to be a way that is very readily received and very possible.

It occurs to me that you have already got in place the RCS vet centers who are in the communities and ideally placed to pass that kind of work.

Mr. SMITH. I would like to add a little to that. I think that Dr. Blank and Dr. Silver are correct in saying that the Readjustment Counseling Service and the vet centers have been outstanding in doing that kind of work, and a good deal of my work over the last few years has been doing that same kind of work with the vet centers and for the vet centers.

However, I think it is also important to note what Steve has said about his unit, that in fact there are multiple demands on those vet centers as they exist. The likelihood that vet center people are going to find time suddenly in their 80-hour weeks to take out time and now begin writing for the public is, frankly, highly unlikely. I think that the intent of the legislation in suggesting that we take on this task to begin writing and designate people we're going to have to do that, charge them and give them the time to develop those materials, is something that is very important for us to do.

We have the horses to do it. Certainly many of the people here could do some of that. The problem is they are so taxed with their clinical demands and the other needs in the medical centers that they don't really have time to do it. I think the legislation is supportive in that it is suggesting we take that more seriously.

Mr. **Edgar**. Thank you.

Let me ask each of you to respond to this. In your personal opinion, do you think the centers of excellence for PTSD in our bill, H.R. 4833, will enhance the VA's ability to treat veterans suffering from PTSD?

Dr. **Arnold**. I would like to comment on that, at least briefly, sir. I have some reservations about the manner in which that would affect the VA's service delivery as a whole. I have not been impressed that the GRECC's so far have influenced the quality of care provided to the elderly. Of course, one can assume that this is gearing up in research and in training for a problem that will be much more intense perhaps 10 years from now. On that basis, the GRECC's, who devote their time to research on Alzheimer's disease, for instance, may be coming up with information that can be used in the medical community generally, where in the VA there will be many aging veterans in 1990 and the year 2000.

I think since we are dealing with Vietnam veterans who have been waiting already more than a decade for treatment, and since it is clear that there are treatment methods which are effective, that it is more urgent and much more reasonable to provide a better responsiveness to their needs and a more specialized approach at this time.

With limited resources available in health care generally, and to the U.S. Government, and certainly to the Veterans' Administration, I would anticipate that whatever those resources may be, if they are allocated to a few places, the available resources for all of the other potential providers of care of veterans with PTSD now would be no better off than they are at the present time—perhaps less so.

There is the potential for looking at the specialized centers of excellence as the whole ball of wax in dealing with Vietnam veterans with PTSD, and perhaps while it wouldn't be intended to contribute toward, if not a downturn in the activity, at least a deflection of the VA's top administration attention to this very pressing problem as it exists everywhere.

I would agree that there is a great need still for research, and certainly a great need for education. But Vietnam veterans today are in their late thirties and early forties. Those who have PTSD who have never been treated successfully have had their symptoms for a very long time. They are getting more and more difficult to treat. Efforts which improve the capacity to meet their needs now would seem to be of the highest priority.

In looking at the staffing requirements for those programs, I think it is reasonable to say with the staff mix that is usually utilized for inpatient and outpatient programming, that somewhere between 15 and 18 staff people can be financed, including fringe benefits, for something around $500,000 to $600,000. An increment of staff, to augment existing commitment of resources at a facility, would enable the operation of a very responsible program not so minimally staffed, not one that presented hazards to the veterans and the staff people, not one that prevented carrying out research and training and the full range of treatment modalities, for much less than has been estimated so far.

Mr. **Edgar**. Do you think there will be any value in meeting the training needs that you are talking about, of the staff as it expands through these centers, or do you think that that can be provided otherwise?

Dr. **Arnold**. I don't believe it can be provided in any other way. There is no substitute for making a program a focused one which is given high attention and given the resources to carry it out.

Mr. **Edgar**. Were there others that wanted to respond to that same question?

Mr. **Smith**. I just wanted to follow what Dr. Arnold was saying. As we were talking about Cleveland, we very much had in mind what Dr. Arnold was talking about—not becoming a center of excellence that simply was recruiting university people with a lot of research dollars. The structure of how we have done that program to build in the evaluation and the research has been to look at how can we build into the existing staff and the existing requirements outcome evaluation, so that we can document what we're doing and create, with a minimal amount of staff, an atmosphere whereby competing for NIMH research dollars, VA research dollars, which would not at all affect the amount of money allocated for treatment services, we could provide excellent treatment while at the same time contributing—documenting those services and contributing to the basic research on PTSD that was going to do that.

Mr. **Edgar**. Dr. Arnold, regarding the outpatient portion of the program at Bay Pines, did you find that existing restrictions on eligibility for service interfered with the treatment?

Dr. **Arnold**. At Bay Pines it didn't, but that was primarily because I took an administrative position in providing that service. The outpatient treatment in most VA's is very limited in staffing capacity. Service-connected veterans are given a priority and usually you don't get down past that priority. Most of the Vietnam veterans were not service connected. It is entirely legal and legitimate to provide followup care for non-service-connected veterans after inpatient treatment and within the available resources to treat non-service-connected veterans. I identified members of the staff who were interested and who were familiar with PTSD who began to work on outpatient treatment of Vietnam veterans, and the remainder of the workload was shared by the other treatment teams. We simply made it a high priority for that team. The intake was handled through the combined inpatient/outpatient Vietnam programs, so that to some extent it was separate from the mental hygiene clinic.

Mr. EDGAR. Thank you.

Mr. Gusman, how many people were turned down for admission at the Menlo Park unit last year, and do you believe that 90 beds is adequate for the entire western quarter of the United States for this program?

Mr. GUSMAN. You want to send me to Wichita Falls. [Laughter.]

Let me start with the situation in the western part of the country. As I understand it, right now there is interest in Washington in starting a program in the Seattle area, and also there is some interest as I understand it in the southern part of California in opening a possible program.

It is really difficult to come up with a figure of how many people are in need of such a program. I don't think there has been any real clear study and I am really uncomfortable with——

Mr. EDGAR. Do you have a waiting list?

Mr. GUSMAN. We have a waiting list, not like Dr. Silver's. Our waiting list varies. What happens is it can go anywhere from two to six people that might have to hang on for possibly 2 weeks. What we do, if somebody needs to be admitted in an acute crisis sort of situation, he will be admitted immediately to a unit close by, and then we will provide the treatment for that person.

We have been very fortunate in developing a close liaison with our admissions area and they have developed some expertise in diagnostic skills in looking at PTSD. So we are much more fortunate than some of the other programs.

I also think it is important to note that the admission policy and procedures are different at every medical center. Once again, the program at Menlo Park was stimulated by the chief of staff back in 1977, so there was administrative support from the onset.

I wanted to comment about one thing, traveling back a little here. I also would agree with the concern about these units, the so-called proposed 15 units, becoming research oriented. Where I reside at Menlo Park, Palo Alto, we have a lot of research going on. We do have an outstanding GRECC program. But I also am very aware that a lot of the things that have developed for the aged and other veterans have developed not through research but have developed from the interest of the house staff. I do believe there is a need for some research. I do believe there is a need to build in an accountability system. But I think that that could be done without having all 15, if 15 should come to pass, but possibly 3 across the country.

I think the problem that has not been recognized—and I tried to make that statement in my testimony—is that Vietnam veterans' problems, albeit they might seem similar from a psychiatric standpoint, from a socioeconomic standpoint they are different. The Vietnam veteran in New York requires a little bit different intervention than the Vietnam veteran who resides in the Bay Area in California—and the same thing for the Midwest. I think we have to pay attention to that.

Mr. EDGAR. Coming from the East, I can understand the differences. In fact, I thought maybe you were going to say, when I asked you the question about waiting lists, whether or not the whole population of California was on your waiting list. I didn't ask that. I didn't say that. [Laughter.]

Let me close with one final question to the whole panel. What has been the most serious problem in establishing a post-traumatic-stress disorder unit? Has it been lack of resources, lack of qualified staff? Are there some other things we're not looking at in terms of the establishment of these centers? What's the proper balance?

Mr. GUSMAN. I think that there are some multiple problems. One is, which has been addressed already, the lack of understanding of the problem of PTSD within the system itself. The other is that the system itself is overtaxed. In working with veterans from different eras, I find it difficult to take from one veteran to try to help another veteran. I find that very distasteful and unprofessional. Right now we're talking about Vietnam veterans, but as somebody said earlier, there are also Grenada veterans and veterans to come.

The other problem we have is, of course, in the issue of support. When we're talking abut support, I would talk about concrete support. That is in the area of budgeting. I think that needs to come in some fashion, clearly delegated to that area for the treatment of PTSD and not specifically to sort of harness that for Vietnam veterans. I also agree with Jack, to look at post-traumatic-stress disorder—we are already, in fact, in our unit we have had World War II and Korean veterans.

Mr. EDGAR. Dr. Silver.

Mr. SILVER. I think the greatest problem we have encountered centers around the issue of staffing, both in providing staff and also in dealing with things like staff ignorance, indifference, and hostility toward the patient population and the idea of treating these folks. That has been a problem from the beginning and it is still a problem. It varies from hospital to hospital to hospital. I have been brought into a number of different VA's and a number of different RMEC's to do teaching, and we find that, as in most institutions, it permeates from the top down in a particular medical center. But there are VA's for example, which pass around among their psychiatric staff literature dealing with people who are faking the symptoms of post-traumatic-stress disorder as clinical case examples that all these folks are phoneys. That kind of attitude I think has been a major problem we have encountered, not simply because it means it's going to be more difficult for treatment resources and treatment to be provided to veterans, but that the whole VA has become tarnished with that image, and as a result, Vietnam veterans, except in extreme situations, tend to prefer not to have anything to do with mainstream VA.

I think that is one of the reasons why the vet centers have been so successful. They have manged to keep that umbilical cord to the VA somewhat camouflaged.

So I think we are still dealing with the issues we were confronting when we started out, and they are still mostly problems with staff.

Mr. EDGAR. Dr. Silver, you mentioned that there was an 8-month waiting list. Can you quantify that in terms of how many numbers of people we're talking about?

Mr. **Silver**. Sure. It is easy to quantify. We have about 28 people on our waiting list right now. We are turning people away from consideration—this doesn't mean we have evaluated them and found them inappropriate. It means we just won't evaluate them because they are some distance away and they would add more on to it.

You can figure out how long it would take for somebody to come in when you realize we have a 4-month program—that's contract; most people stay longer—say 13 people in the program at any instant, it is going to take 4 months to rotate them through. If you have more than 26 people, you're talking more than 8 months to get all the way through.

The people we admitted yesterday were lucky. We only interviewed them I think to the day 6 months ago. Our waiting list has been getting longer, not shorter.

Mr. **Edgar**. Thank you.

Your request for additional resources at Coatsville, is it being honored?

Mr. **Silver**. I have no idea. It has gone up the chain of command and I don't know what its status is at this time.

Mr. **Edgar**. Let's assume it is honored and we'll hear about it next week, for purposes of discussion.

Dr. Arnold.

Dr. **Arnold**. Mr. Chairman, I would agree that the major problem is staffing. I have a different problem with staffing in Phoenix than I had at Bay Pines, and I suppose this was more common several years ago, 3 years ago. But the staff there weren't familiar with PTSD and there was a difficulty in acquainting them with it, in addition to the numbers. But I think, though, the shared problems in the Sun Belt have an impact on this. Vietnam veterans, as well as other veterans, are moving to the South, and where populations of veterans are rapidly increasing, the staffing of the VA medical centers is not keeping pace. This was a serious problem at Bay Pines, finding the staffing. It is even more serious at Phoenix I find. There are 10 counties that the VA has found to have the largest veteran population, and the county in which Phoenix is located is one of those, and Phoenix is also located in one of the only three counties amongst that group whose veteran population is continuing to increase, which means that the whole workload of the hospital is simply swamped.

There has been an informal waiting list amongst Vietnam veterans in Phoenix for a PTSD unit I find for several years before I arrived there. It is simply at this point impossible for the administration of the hospital to see a feasible way to begin to provide even a few staff to start up a unit, when adequate nursing staff at night or enough pharmacists to fill prescriptions or whatever the basic care needs may be. Yet at Phoenix, at least, the level of interest and knowledge on the part of the staff, particularly the staff who work in psychiatry, is very great. There is an enthusiasm and a desire to work on a specialized program. So there it is not an issue of training; it's an issue of numbers.

Mr. **Edgar**. Thank you. Mr. Smith.

Mr. **Smith**. Fred has said especially most of the things that need to be said about that. The only thing I would emphasize is my experience in trying to look at what the programs have done. How they developed the program in Cleveland was by local support. The hospital director, the staff, and the heads of the services in the hospital, having that kind of support is especially critical, as Fred said in the development of his program and in the other ones. Art Arnold's support at Bay Pines was what got that unit off the ground.

In addition, there is the problem of education. My experience has been that people are not neutral about this topic of post-traumatic-stress disorder. People are either enthusiastic and support it and are anxious to know, or they are fearful and ignorant. The best way that we have had of dealing with this is to deal with people face to face in these training programs that the RMEC's have set up, and also to have the opportunity to go in and consult in the hospitals, where we actually sit down and talk about a particular client.

All right, let's say this guy is a character disorder and it has nothing to do with PTSD; how would he react and how would we treat him; what has been successful. We go down the line and they say it doesn't work, we've tried all that stuff. Well, let's try an alternative. Does it fit with "*x*". We go down and actually talk about this, suggest some ways, and then they say, "Oh, my God, then this does fit. He does seem to be responding to this." Then we've got a convert. Then we've got somebody who was a disbeliever and has acutally had the experience. So having funds so that we can do some miniresidencies, so that some of the expert staff that you've got here and that exist in this program will have time to spend time at other medical centers, for people at other medical centers to come and spend time being trained, that's what is going to spread the word to the system over a period of time.

Mr. EDGAR. Thank you very much. I do want to tell Dr. Smith that you are permitted, given the excellence of your testimony, to take your "Dr. Smith" sign with you and make that the first contribution to calling you doctor.

I want to thank all of you for your help and your work over the years in trying to focus on this issue. It is an important issue. We hope that you will go back and take a second look at the draft legislation and do some technical corrections. It doesn't take lawyers to know how to write laws. It just takes a little common sense and it would be helpful to see some of the corrections that you might like to make. You can submit those to us.

We really appreciate what you have done in terms of cutting the edge of a new issue, at least identifying it as an issue, that is important for us to deal with here in this committee. Thank you.

Mr. EDGAR. I would like both of the panels to come forward at this time: Mr. Paul Egan, Mr. Sommer, Mr. Gorman, Mr. Mayo, Mr. Stone, Mr. Passamaneck, and Mr. Terzano, if you will all come forward at this time and find a place or pull up a chair around the table.

I would like to have a recorded message that says "I apologize for keeping you so long." Our hearing has gone longer than anticipated.

The full text of all of your statements will be made a part of the record. In order that we not be duplicative, I hope that you will focus on the bottom line of each of the issues, each of the points that you will raise. We don't have the kind of time that I would like to go into in-depth philosphical discussions with you on all of these matters, but I do appreciate your patience and your listening and your ability to put testimony together.

We will hear first from Mr. Paul Egan, deputy director, National Legislative Commission of the American Legion.

STATEMENTS OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AND JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DAVID W. GORMAN, ASSOCIATE DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; PHILIP B. MAYO, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; HARRIS B. STONE, NATIONAL EXECUTIVE DIRECTOR, JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA; LT. COL. DAVID J. PASSAMANECK, U.S. ARMY, RETIRED, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND JOHN F. TERZANO, LEGISLATIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

Mr. **Egan**. Mr. Sommer will give our statement, Mr. Chairman.

Mr. **Edgar**. Fine. Mr. Sommer, please proceed.

STATEMENT OF JOHN F. SOMMER

Mr. **Sommer**. Thank you, Mr. Chairman. The American Legion appreciates this opportunity to summarize our views on the issues under consideration today.

We support the intent of H.R. 4833 to provide treatment to any eligible veteran who served in Vietnam and who is determined to be suffering from post-traumatic-stress disorder, without regard to any limitation contained in title 38 on the furnishing of such services by the VA. The measure, as we understand it, would fund the 10 existing PTSD treatment units and provide for the establishment of additional units, not to exceed a total of 15. Importantly, resources would be allocated in the VA budget for the funding of these treatment units.

Realizing the need for research and the education of health care professionals regarding the causes, diagnosis and treatment of PTSD, we were pleased to see that these issues are adequately addressed in the legislation.

The American Legion does have one question regarding one provision of H.R. 4833. If the establishment of PTSD treatment units is limited to no more than 15 VA medical centers, what is to be done in the case of veterans with severe PTSD requiring inpatient treatment when these veterans reside in the catchment area of a medical center where a treatment unit is not available?

Mr. Chairman, the Legion pointed out during this subcommittee's hearing of March 24, 1983, that a disturbing conclusion drawn from the site visit reports prepared by our field representatives, and from complaints lodged by American Legion service officers, is that many VA physicians have differences of opinion regarding post-traumatic-stress disorder, including the diagnostic criteria and the credibility or even the existence of a PTSD diagnosis. It was also reported that some VA physicians discount any mention of Vietnam service or combat during an evaluation, and others do not elicit any military background at all during a PTSD examination.

Unfortunately, we have seen little improvement over the past year. Therefore, the Legion feels there is a great need for research and an extensive education of VA health care professionals regarding the causes, diagnosis, and treatment of post-traumatic-stress disorder. Therefore, we were pleased to hear this morning that the VA has seen these needs and is beginning to address them.

The problems relating to the manner in which some VA facilities are handling the issue of post-traumatic-stress disorder are extremely disconcerting to the American Legion with respect to the inconsistencies in the diagnosis and provision of treatment at VA medical centers, and the adjudication of claims in the regional offices. We have, since early 1982, continued to track these problems. Our full statement contains examples reflecting how PTSD is handled at various facilities, the problems that have been identified by our staff, and in some instances by VA personnel.

While we realize that the adjudication of PTSD claims by VA regional office rating boards is not under consideration during this hearing, there is a relationship between the disability of evaluation examinations and the rating of these cases, and it must be said that we are finding problems with respect to this relationship.

There appears to be no consistency in the treatment of PTSD on an inpatient basis throughout the VA medical care system. It appears, from what we have been able to gather, that individual psychiatrists oftentimes incorporate their personal methods of treatment, regardless of their proven effectiveness. To the American Legion, this demonstrates the need for research on the treatment of PTSD. In the interim, a temporary solution might be to ask the clinicians most knowledgeable in this area to write a program or guidelines on the best proven methods of treating PTSD. This would at least provide consistency throughout the system.

The American Legion has found there are a variety of problems associated with the adjudication of PTSD claims. Some relate to the lack of documentation of the "stressors" of duty in Vietnam. There is the problem of psychiatric examinations that are less than adequate and the subsequent negative impact on ratings based on such examinations. And there are problems resulting from the attitudes of some VA personnel.

With respect to the inaccurate rating examinations, many times we found that no military history was elicited from the veteran during the examination, and although the veteran exhibited symptoms such as recurrent dreams about being killed in Vietnam, survivor guilt, startle response, limited social or interpersonal relationships, et cetera, the examining physician arbitrarily states that there is no evidence to support a diagnosis of PTSD.

It is also apparent that some examinations are conducted by individuals who are unfamiliar with the information needed to rate the case. The American Legion has found the adjudication of PTSD claims to be extraordinarily stringent in a significant number of cases. This is also substantiated by the comments that we're receiving from psychiatrists and psychologists at some VA medical centers.

While the American Legion is aware that problems do not exist in every medical center or regional office, it is disturbing to know that any Vietnam veteran is not receiving fair and equitable treatment by the Veterans' Administration. The Legion will not tolerate employees of the Veterans' Administration who unilaterally decide that PTSD is not a valid diagnosis. That issue has been settled and appropriate directives have been issued. Any VA employee who will not, or cannot, accept it should not be in VA service.

In conclusion, Mr. Chairman, the Legion will continue to monitor all activities relating to the handling of PTSD by both VA medical care facilities and the regional offices. We insist that these Vietnam veterans, who continue to bear the burdens of their war service, are to be treated compassionately and objectively in their quest for answers and solutions to their readjustment problems.

Mr. Chairman, that concludes our summary.

[The statement of John F. Sommer appears at p. 162.]

Mr. EDGAR. Thank you very much for your statement.

Mr. Gorman, the associate deputy national legislative director, Disabled American Veterans.

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you very much, Mr. Chairman. I will try to make my remarks very brief in this summary.

With reference to H.R. 4833, as listed in the full text of my testimony in written form, we do have two concerns about this measure as currently constructed. First is the absence of any language requiring that veterans eligible for the comprehensive services outlined would be service connected for post-traumatic-stress disorder. We would, therefore, suggest that language defining the eligibility criteria be amended to stipulate and ensure the eligibility will be for service-connected disabled veterans suffering from post-traumatic-stress disorder.

Second, we are concerned by the fact that this measure would only apply to veterans of the Vietnam era who suffer from post-traumatic-stress disorder. We would also like to suggest, Mr. Chairman, that the language in H.R. 4833 again be amended to include that these services will be provided to any veteran suffering from post-traumatic-stress disorder.

With respect to the veterans readjustment counseling program, Mr. Chairman, we are in agreement that the vet centers have generally proven themselves to be successful in assisting Vietnam veterans and their families.

Mr. Chairman, you and the members of the subcommittee are to be commended for recognizing the need to integrate the services now provided by vet centers directly into VA health care facilities. I am referring, of course, to the enactment of Public Law 98-160, which required, in part, the orderly transition of readjustment counseling services from a program currently provided primarily through centers located in facilities apart from the VA health care facilities to a program providing readjustment counseling services primarily through VA health care facilities. By doing this, Mr. Chairman, the VA will not only bring all treatment modalities into existing VA facilities, but will be able to phase out as well the existing contract services to a large degree that are being utilized to provide such services.

That concludes my testimony, Mr. Chairman.

[The statement of David W. Gorman appears at p. 180.]

Mr. **Edgar**. Thank you very much.

Mr. Mayo, Veterans of Foreign Wars.

STATEMENT OF PHILIP R. MAYO

Mr. **Mayo**. Thank you, Mr. Chairman.

The VFW supports the thrust of the meaure before the committee today, and our concerns are detailed in our written testimony. The vet center, or the readjustment counseling program, we believe, is generally a model of success. We support its expansion and improvement in order to meet the growing demands on its resources, as well as the commitment of additional resources for improved inpatient care.

That concludes my summary.

[The statement of Philip R. Mayo appears at p. 190.]

Mr. **Edgar**. Thank you.

Mr. Stone, Jewish War Veterans.

STATEMENT OF HARRIS B. STONE

Mr. **Stone**. Mr. Chairman, what I heard this morning led me to deviate slightly from the prepared testimony, because I am convinced that it is best to have adequate staff in-house rather than to contract for services. The constant cutback in Federal employment and the degrading of such employees precludes establishing a viable recruiting program today. Therefore, in our testimony that was submitted, we say the nonuse of money to secure needed services demonstrates a lack of planning, a lack of priority, and a lack of management commitment in the VA toward this program, I don't care what laws you pass, how much money you appropriate, if it is not used, if it doesn't procure the necessary services, we're not going to take care of the situation that has been evidenced by PTSD.

I think Congressman Weiss said it clearly when he asked the questions, which I still haven't heard answered by anybody—I'm talking in the VA—"Why has the VA not prioritized the funding of a national program to research and treat post-traumatic-stress disorder?" The second question he asked, which is still unanswered, "Are doctors and officials of the VA fulfilling their obligation to Vietnam veterans, or any other veterans for that matter, or are there biases which get in the way of doing so?"

Thank you, Mr. Chairman.

[The statement of Harris B. Stone appears at p. 186.]

Mr. **Edgar**. Thank you.

Lt. Col. David Passamaneck.

STATEMENT OF LT. COL. DAVID PASSAMANECK

Colonel **Passamaneck**. Thank you, Mr. Chairman.

AMVETS appreciates the opportunity to come and comment on this extremely sensitive and what we consider to be vital piece of legislation, particularly the subject which it concerns. We enthusiastically support H.R. 4833, to provide comprehensive treatment services to veterans who served in Vietnam. We would advocate extending the program to all veterans who suffer from post-traumatic-stress disorder.

The diagnosis and treatment of the psychological scars of the Vietnam war and others have been recognized by the inclusion of diagnostic code 9411, post-traumatic-stress disorder, in the VA schedule. However, the professional orientation of the health care providers has not sufficiently recognized or understood the realistic horrors of this insidious reminder of those terrible years for so many of our combat veterans. The provision for specialized treatment centers for both therapeutic and educational purposes should serve to improve the understanding and recognition of the condition.

We would suggest, however, that in order not to unduly restrict, or possibly unduly restrict, the treatment for PTSD, that the word "only" in (c)(1) of the proposed new section 620(B) of title 38, United States Code, be deleted and that (3), the September 30, 1988 cutoff date also be deleted. If the program outlives its usefulness at some future date, amendments can be enacted at that time to address that problem, or, shall we say, the lack of a problem.

I would also like to reiterate our position emphasized by our national commander before the Joint Veterans Committees of the Senate and the House yesterday, when he urged enactment of legislation requiring the opinion of at least two psychiatrists in rating a veteran for PTSD. We would advocate inclusion of such a provision in this bill. In other words, we feel it is extremely arbitrary, unreasonable and harsh to automatically dismiss a veteran's claim which might be cognizable under PTSD by the opinion of just one physician, who may not even be a psychiatrist in many cases.

Of course, we have always supported the vet centers. We feel they are working very well. At least they are going a long way toward accomplishing the purpose for which they were set up. We feel they should be strengthened and continued.

Thank you, Mr. Chairman.

[The prepared statement of Colonel Passamaneck appears on p. 194.]

Mr. EDGAR. Thank you very much.

I yield to Mr. Terzano to conclude the panel. All of your statements will be made a part of the record. Your information will, in fact, be looked upon as we rewrite the legislation for markup, and we await Mr. Terzano's comments.

I ask unanimous consent, at the conclusion of his comments, that the committee stand adjourned. I am going to slip away while he makes his comments to vote.

STATEMENT OF JOHN F. TERZANO

Mr. TERZANO. Thank you, Mr. Chairman.

At the risk of being accused of being a little melodramatic here, I would like to let this committee know what happens to individuals who cannot get into the PTSD treatment units, and the quality of treatment for individuals that do get into the PTSD treatment units.

There was an individual here in Washington, DC, whom VA had come in contact with who was in desperate need of inpatient psychiatric care. Because there was not a PTSD unit in the Washington, DC, area, we told this gentleman that we were advised that it would be best to put him into the inpatient psychiatric unit at the VA hospital in Washington, DC, and then an the evaluation would be made that would enable him to be transferred to a PTSD unit somewhere in the country.

Unfortunately, this individual spent 6 months in the inpatient psychiatric unit here in Washington, DC. This counseling consisted of one rap group a week and he was asked to make plastic toys—tanks, I might add. This individual is now back out on the streets, still troubled and no better off then he was 6 months ago, but to the inpatient facility here in Washington, DC, he's OK.

The other case involves an individual who I will mention by name, Karl Lerchenmuller. Mr. Lerchenmuller was an individual up in New York who had a long history of psychiatric problems. He also had a history of suicide attempts.

Last year, after an altercation with police in New York, he was arrested and originally charged with attempted murder on a police officer. The charge was later reduced to menacing with a gun. The judge, in his wisdom, did not remand this individual to jail. Instead, because there was a PTSD unit in Montrose, NY, he thought that Karl would be best served by going into this unit, seek treatment, and upon completion of the program he would be able to face the charges pending against him.

It should be noted that while he was a member of this unit, he attempted suicide. One day he and another patient stole some silverware from the cafeteria. Unfortunately, somebody within the psychiatric unit thought it would be best to call the State police. The State police came in and arrested the two individuals.

They were released by the police and sent back to the hospital, adequate treatment, unfortunately was not forthcoming. On a day pass to go to court on the silverware incident, Mr. Lerchenmuller proceeded to drink, went into court, caused some problems, and was subsequently arrested and thrown into jail. That night he hung himself in his jail cell.

The reason for bringing up these two incidents, quite frankly, is because VVA is concerned about the quality of care afforded veterans in these facilities. There are individuals like Steve Silver, Dr. Arnold, Fred Gusman, and Jack Smith, who run tremendous programs, and do a great service to veterans. We have worked in getting some people we know into these programs. I have known personally individuals that have gone through the Menlo Park program and the success rate is tremendous.

What worries us is the lack of some type of guidelines, general as they may be, coming out from central office, to give people at least a road map on how they should be treating these people. Dr. Jack Smith alluded to that earlier, and I think it is important that we move forward in providing the necessary directives that would assure a consistent quality in the treatment of these veterans.

Finally, I would just like to say, in terms of the reprogramming of the $7.2 million and the additional 220 FTEE's that this committee has requested of the Appropriations Committee, I am well aware that it is going to fall upon the veterans' service organizations to carry the fight to the Appropriations Committee. That is a responsibility that, quite frankly, we feel up to taking. But I also feel it is a question of leadership on the part of the VA. If for just once, the VA, principally the Administrator, would go to bat for Vietnam veterans, and walk into the Appropriations Committee himself and say "We want this money for this program, we want these additional FTEE's," that would make our job a lot easier.

That concludes my statement.

[The statement of John P. Terzano appears at p. 197.]

Mr. McDONELL. Thank you very much, gentlemen, for your testimony.

[Whereupon, at 12:45 p.m. the subcommittee was adjourned.]

APPENDIX

STATEMENT OF
DONALD L. CUSTIS, M.D.
CHIEF MEDICAL DIRECTOR
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

March 29, 1984

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before you today to comment on H.R. 4833, a bill to provide comprehensive treatment services to veterans of the Vietnam theater, who are suffering from PTSD, and on the operations of the Veterans Administration's Vietnam Veterans Readjustment Counseling Program.

H.R. 4833 would establish a statutory framework authorizing VA, until September 30, 1988, to provide treatment for post-traumatic stress disorder (PTSD), but only within a specific program model mandated by this bill. Veterans who would receive their care under this new section could be treated only in special units established for treatment of the disorder. The bill would limit to 15 the number of VA facilities at which such units may be established. The bill would require that these units also sponsor efforts to educate health care professionals, including those employed outside the government, regarding PTSD and would require the Agency to give priority in allocating funds for research relating to PTSD to medical facilities at which these treatment units are located. The bill would also require VA to identify each year in material submitted with the President's budget the resources proposed to be allocated to these treatment units. The bill calls for VA to compile and publish regularly its research findings on PTSD and to promote the exchange of information about that disorder among health-care professionals. Finally, the bill expresses the intention that facilities having special PTSD treatment units in existence on October 1, 1984, be considered to be among the 15 facilities covered under this measure, unless the Administrator determines otherwise.

We consider the effective care and treatment of PTSD, as well as efforts to expand the understanding of health-care professionals regarding the diagnosis and treatment of that disorder, to be critically important aspects of the VA's responsibilities. We therefore support the objective embodied in H.R. 4833. In fact, we are encouraging the development of PTSD units at our VA medical centers. However, we believe that there is no need to enact this legislation. VA already has broad statutory authority to achieve the purposes of this bill and has made significant strides in these areas. Since we do not believe there is any need for legislation in this area, we do not favor enactment of H.R. 4833.

Post-traumatic stress disorder is a reactive condition that was not officially recognized by psychiatry as a specific mental disorder until 1980. Nevertheless, VA is active in providing treatment for PTSD to veterans--in Vet Centers, mental hygiene clincs, psychiatric inpatient treatment programs, and special inpatient units that have been or are being developed at 12 VA medical centers. It is also noteworthy that on January 5, 1984, we published a request for contract proposals for a major study on PTSD mandated by Public Law 98-160.

VA has broad authority to provide treatment for veterans suffering from PTSD, and to sponsor research and education on this subject. This additional statutory authority is unnecessary.

Our experience with the treatment of PTSD does indicate a need for additional treatment capacity in the Veterans Administration. This bill anticipates the development of such additional capacity through designated treatment units. In providing for VA to expand the number of designated PTSD units, the bill appears to call for the development of centers that would have the general cast of VA's geriatric research, education, and clinical care centers (GRECC)--blending into one arena treatment, education, and research on this disorder. Our clinical care needs are such that we would want to apply the GRECC model judiciously. Indeed, our planning would not be to commit all our units to a research and education mission.

Although we do not believe this bill is intended to limit to 15 medical facilities all VA care and treatment of PTSD, we are concerned that, as drafted, it might limit VA's establishing more than three new designated PTSD units until 1988.

Lastly, the bill raises certain technical questions regarding eligibility for services. For example, while the caption to proposed section 620B and new subsection (a) of that provision suggests that the drafters do not intend to expand eligibility for services, proposed section 620B(b)(1) would appear to create broad eligibility for care of any disorder suffered by a Vietnam veteran who has been determined to suffer from PTSD.

We project that enactment of H.R. 4833 would result in cost of some $3 million for FY 1985, and total costs of approximately $24.4 million over the four years of the program.

Mr. Chairman, with your agreement, I would like now to turn to the VA's Readjustment Counseling Program for Vietnam Veterans.

During the past four years, this program has become the spearhead of the Agency's outreach and counseling services to veterans of the nation's longest and most difficult war. Today, staff are at work in 135 Vet Centers nationwide, providing a wide variety of services, and seeing large numbers of clients, both veterans and family members.

By the end of February 1984, the Vet Centers had counseled 226,593 veterans, and approximately 50,000 family members, since the program began in late 1979. The Vietnam veterans' response to VA outreach efforts is a happy outcome of some long and difficult years of alienation between the Veterans Administration and many Vietnam veterans. With over a quarter of a million persons seen, by all indications we believe we are experiencing very high client satisfaction with services.

The original design of the program has proved effective, relying on about 60 percent of staff who served in Vietnam, with an additional 15 percent being Vietnam-era veterans. There are currently 556 professionals and paraprofessionals providing direct readjustment counseling services at 135 Vet Centers. Six Regional Managers and staff have direct line supervisory responsibility over Vet Center staff. Similarly, our original concept of multiple services provided by a mix of professionals and paraprofessionals, has stood the test of time. Vet Centers in most locations have now become a prominent, successful, and highly consumer-reponsive element in the VA service structure. Most importantly, they have brought community reintegration, employment, renewed psychological health, and hope to tens of thousands of Vietnam combat veterans with post-traumatic stress disorder and other readjustment problems. In so doing, both veteran and community have been assisted in overcoming the emotional wounds of the Vietnam War.

Public Law 98-160 extended the Vet Center program through Fiscal Year 1988. Equally, or more important, it eliminated the expiration date on the eligibility period thereby providing Vietnam-era veterans with ongoing eligibility to request readjustment counseling. This statutory change signals the fact that assistance for readjustment problems is properly a central, ongoing part of the medical care mission of the Veterans Administration.

I would like to proceed now, Mr. Chairman, with the progress of the Readjustment Counseling fee-for-service contract program. Following a protocol formulated by the Readjustment Counseling Service in 1979, contracting committees at over 100 sites, including both Medical Center and Vet Center staff, awarded competitive contracts to 530 individual practitioners, group clinics, and community agencies across the country. Through the end of February 1984, the contract providers had seen a total of 23,016 veterans for a total of 165,290 visits. Expenditures for the contracts program have increased steadily since FY 81 and close monitoring of this program is a needed improvement. On October 19, 1983, I appointed a task force and charged them to develop a plan that formulated a mechanism for monitoring the Readjustment Counseling Fees/Contracts Program. In January 1984, I sent a letter to each medical center instructing them to conduct an internal control review of the fees/contracts program. This phase of our internal management was completed last week. We are now analyzing the data and we expect to take immediate action to resolve the problems identified in our nationwide survey.

At the start of the Readjustment Counseling Program in 1980, the program's highest priority was to establish and get operational, the Vet Center storefront operations to begin serving veterans with VA staff. However, the other major portion of our original authority, the contract/fee program, is now fully operational. While fully in place as an operational entity, the contracts/fee program is not problem free. Our early concerns for utilizing this authority were that we would have limited control over the quality and integrity of the contract services provided. Our concerns have been borne out and the VA Inspector General has reported findings indicating a need to determine client eligibility in a more timely manner and to require that contractors provide formal documentation to evidence that billed services have been provided to clients. Department of Medicine and Surgery program officials worked closely with the Inspector General in developing the audit plan to detect the program areas of vulnerability. We have begun, through a task force effort, to take corrective action to bring these and other vulnerable areas under our management control.

The Vet Centers are closely supported by my office and as well by the Deputy Administrator, who chairs the Agency's Readjustment Counseling Steering Committee, which meets several times a year to review all aspects of program operations. Additionally, last year, the Administrator appointed an 19-member Readjustment Problems of Vietnam Veterans Advisory Committee, a GSA federally-chartered Advisory Committee. This committee is well into the task of providing not only the Readjustment Counseling program, but other VA medical care and benefits components, with thoughtful and vigorously independent advice and counsel. I am especially pleased to report that of 19 committee members, 13 served in Vietnam, and of those, 6 are key officials of congressionally-recognized veterans' service organizations.

In many ways the Vet Center program has developed and progressed far beyond what any of us might have expected. Support for Vet Center operations has burgeoned at the local level. Most centers have several volunteers including work-study students, state disabled veterans outreach employment counselors, professional mental health volunteers from both VA medical centers and the private sector, and, almost all Centers have established good cooperation with veterans' service organization posts and chapters. Vet Center staff and volunteers have become advocates for Vietnam veterans not only in VA medical facilities, but in many community agencies. During the past year especially, most of the Vet Centers have developed close clinical collaboration with VAMC mental health professionals, who themselves have begun to provide increasingly effective assistance to veterans with war-related problems.

When this program was designed, it was anticipated by some that it would largely provide relatively brief and superficial supportive counseling to veterans, with an emphasis on referral for more definitive treatment, and that it would complete its mission in three years. Those assumptions have not been borne out.

About 40 percent of Vet Center clients are troubled by post-traumatic stress disorder to some degree, about 50 percent have a variety of readjustment problems in other areas, and perhaps 10 percent are seen primarily for evaluation and referral. A substantial number of the veterans with PTSD also have other life problems. Overall, as has been the case since program inception, employment difficulties remain a very common presenting problem.

The greater-than-expected percentage of clients with stress disorder, some of whom are severely troubled, has required the provision of extensive counseling and psychotherapy.

We have therefore increased the proportion of staff who are mental health professionals, now requiring at least one at each Vet Center, and we have been compelled to maintain an intensive in-service training program nationwide in order to enhance the skills of paraprofessional and nonprofessional staff.

Along with the direct provision of services, and program administration, Vet Center employees are active participants in VA medical facilities and communities, and are recognized as strong advocates and thoughtful counselors.

It has been our experience, particularly in recent years, that VA medical center professionals and community contract providers have turned an important corner in their understanding of stress disorder and their comfort with Vietnam veterans; veterans are increasingly comfortable with our medical facility and contract providers; and, the Vietnam experience is now more-routinely addressed in many service contexts.

In conclusion, we feel that all the changes and refinements in management which are taking place at all levels from Central Office to Vet Centers, are occurring without diluting or detracting from the unique features which have made Vet Centers so responsive to Vietnam veterans: (1) a high proportion of Vietnam veterans staff; (2) a mix of professionals and paraprofessionals; (3) informality in atmosphere and procedures for clients; (4) community location and orientation; and (5) clarity of program goals and objectives.

Finally, Mr. Chairman, this is not to say that there are no longer any problems. But we are confident that these will be solved, because the Agency--the Administrator, the Deputy Administrator, and all those of us responsible for oversight of this program--strongly support it, are proud of its accomplishments, and pleased with its success.

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the committee may have.

PTSD RESEARCH

As of June 1984, the ongoing centrally reviewed and funded research programs in the area of post-traumatic-stress disorder (PTSD) are shown in attachment A. The support for these programs in FY 1984 totals $326,246. In order to stimulate well designed research studies in PTSD, the Medical Research Service has begun an educational process for interested clinicians in the form of a workshop. The workshop is scheduled to be held in October 1984. Its purpose is to assist interested clinicians to submit high quality research programs relevant to PTSD. A copy of the workshop announcement is contained in attachment B.

ATTACHMENT A.—ONGOING RESEARCH PROGRAMS (CENTRALLY REVIEWED AND FUNDED)

VA medical center	Principal investigator	Program title
West Los Angeles (Brentwood), CA	Richard L. Hough, Ph.D	"Delayed Stress Disorders in Hispanic Vietnam Veterans."
Dallas, TX	Ralph Robinowitz, Ph.D	"Developmental Techniques for Adjusting Negative Behaviors from Combat Experience."
Jackson, MS	Milton Kramer, M.D	"The Psychology of the Dream: Dream Anxiety Attacks and Night Terrors."
West Haven, CT	Elizabeth A. Brett, Ph.D	"Imagery and PTSD in Vietnam Veterans."
Boston, OPC, MA	Bessel Van Der Kolk, M.D	"Effect of Psychotropic Medications on PTSD."

○

Department of Medicine
and Surgery
Washington D.C. 20420

Veterans
Administration

IL 15-84-5

March 29, 1984

In Reply Refer To: 151F

RESEARCH AND DEVELOPMENT LETTER

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, Regional Offices with Outpatient Clinics. (10B/RC, 151, 152 and 153)

SUBJ: Research Workshop on Post Traumatic Stress Disorders (PTSD)

1. In January 1984 an ad hoc committee was convened to consider mechanisms to improve the success rate in Merit Review of research proposals to study PTSD. In recent rounds of Merit Review only a small number of proposals to study PTSD have been submitted and these have faired poorly.

2. One of the recommendations of the committee was that a workshop be held to assist VA scientists in the development of their research proposals in PTSD.

3. This workshop will be held on October 24-26 ~~September 20~~-21, 1984, at a location to be determined at a later date.

4. VA medical facility directors are encouraged to submit by June 20, 1984, application packages for individuals who would benefit from the workshop. Readjustment Counselng Center directors are requested to submit application packages to their parent VA facility's Research and Development Office. Successful candidates will be VA clinical and research staff members who are in the process of planning research studies on PTSD. The details of the workshop and application format are provided as attachment A.

5. Attendees will be selected by the workshop faculty. Approximately twenty (20) attendees will be selected. Expenses associated with this workshop will be paid by the Office of Research and Development.

6. Should additional information be required, please contact Dr. Robert E. Allen, Medical Research Service, FTS 389-2441 or 389-2124.

Hollis G. Boren

HOLLIS G. BOREN, M.D.
Assistant Chief Medical Director
for Research and Development

Attachment (See Reverse)

DISTRIBUTION: COB: (10) only
SS (151) FLD: MA-10 each; DO, OC & OCRO-5 each: and RD-2 each
EX: Boxes 63, 60, 54, 52 and 44-1 each

ATTACHMENT A

WORKSHOP ON PTSD

NOTE: Only applicants who are eligible to receive VACO research funds should apply.

Background

A workshop is planned for September 20-21, 1984, to assist VA clinicians and researchers in designing research studies of Post Traumatic Stress Disorders (PTSD). This workshop is intended for individuals who have a serious commitment to developing and implementing research studies in PTSD. Since there will be more applicants than the twenty (20) that can be accommodated, a brief application package is required. The faculty for this workshop will review these packages and select the attendees. The application package should be brief and out-line those areas which would highlight the skills and interests of the applicant. Please use the following format.

I. Applicant's Biographic Sketch (1 page only)

NAME: FTS:

VAMC:

VA Service:

University affiliation:

University Department:

Education:

Name, Location of Institution	Degree	Year Awarded

Research and/or Professional Experience (work backwards from present appointment):

Date(s)	Position(s)

*Provide a list of applicant's publications.

II. Research Interests and Skills (1 page only)

*Briefly describe research projects the applicant has conducted and their relationship to PTSD research.

III. PTSD Research Project (2 pages only)

*Briefly describe the PTSD research project the applicant plans to develop.

By June 20, 1984 Mail to:

Dr. Robert Allen (151F)
VA Central Office
810 Vermont Ave., NW
Washington, D.C. 20420

PTSD Education and Training

PROGRAMS: A total of 40 formal Regional Medical Education Center educational programs on PTSD have been provided since 1979 to 2,521 participants drawn from both outreach and hospital staff. Both groups received training covering the Vietnam experience, combat stress, and on the assessment and management of PTSD veterans. Outreach training emphasized counseling techniques and criteria for referral to hospital centered PTSD treatment programs. Training for VAMC clinical staff emphasized the assessment and treatment of the more severely impaired PTSD veteran. Attachment A contains a summary of these 40 Regional Medical Education Center PTSD training programs.

A total of 1,073 DM&S clinical staff participated in 28 programs of forty PTSD courses listed. A profile of clinical staff participation appears below.

VAMC Clinical Staff PTSD Training Profile

Staff Category	# Courses	# Participants	Total Training Hours
Physicians	26	187	2,890
Dentists	3	5	41
Nurses	23	343	4,061
Associated Health*	24	538	7,229
Totals	28	1,073	14,221

*Includes VAMC psychologists, social workers and other allied health therapists, but excludes Veterans Outreach Center staff.

COSTS: The cost for these PTSD training programs was $299,250 in Post-graduate and Inservice Training (PIT) funds.

Attachment A

SUMMARY OF RMEC PTSD TRAINING TO DATE

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
1. Outreach, Phase I	12	32
Specific Topics: Review of psychological stress in combat with specific emphasis on Vietnam conflict. Review Case History, discussion on 10 year follow-up of veterans with PTSD. Specific treatment and interventions to facilitate the healing process; counseling techniques for PTSD anger and violence.		
2. Outreach, Phase I	12	35
Specific Topics: Repeat of program #1.		
3. Outreach, Phase I	12	30
Specific Topics: Repeat of program #1.		
4. Stress Disorders	18	22
Specific Topics: Definition and course of PTSD (delayed stress) related stressors; symptoms; treatment process; stress reduction.		
5. Stress Disorders	18	40
Specific Topics: Repeat of program #4.		
6. Outreach, Phase II	15	42
Specific Topics: Overview of combat related stress reactions; PTSD; PTSD and conjugal therapy; PTSD treatment issues; Vietnam veteran and management of violence; coping with Vietnam veteran's PTSD.		
7. Outreach, Phase II	15	35
Specific Topics: Repeat of program #6.		

	PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
8.	Outreach, Phase I	20	32
	Specific Topics: Vietnam veteran's with PTSD: family and group counseling; PTSD treatment; PTSD in disabled/women and minority veterans; PTSD legal issues; pre-release PTSD counseling; PTSD and significant others; sexual disfunction and substance abuse.		
9.	Outreach, Phase I	20	29
	Specific Topics: Repeat of program #8.		
10.	Outreach, Phase III	42	130
	Specific Topics: Diagnosis and treatment of PTSD including: group counseling, crisis intervention; dealing with anger; moral/ethical issues; PTSD claims; substance abuse; domestic violence; clinical assessment; and disabled veterans.		
11.	Outreach, Phase IV	45	150
	Specific Topics: Nature and prediction of PTSD: Legal issues; group counseling, disabled veterans, crisis intervention; multi-nodal therapy; marital and family treatment; case management and assessment; female PTSD veterans; issues with women partners; current research in PTSD; substance abuse; case conferencing for the PTSD veteran.		
12.	PTSD	11.5	40
	Specific Topics: Assessment of PTSD: Definition of PTSD; personality issue; combat stress and symptom formation; diagnosis. Treatment of PTSD: Treatment principles; group therapy, Veterans Outreach Center counseling; staff responses to Vietnam veteran.		
13.	PTSD	11.5	48
	Specific Topics: Repeat of program #12.		

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
14. Veteran Center Team Leader Training	14	31
Specific Topics: Clinical case management; clinical research; Vietnam veteran legal issues; confidentiality; and incarcerated PTSD veterans.		
15. PTSD	14	71
Specific Topics: Assessing for PTSD: Fighting the war and returning home; civilians and the Vietnam war; definition of PTSD; combat stress and symptom formation; PTSD versus character pathology; women who served in Vietnam; multi-method assessment. Treating PTSD: General principles; women staff and male Vietnam veterans; group psychotherapy; imaginal flooding and catharsis; Veteran Outreach Center functions and VAMC interactions; staff responses to Vietnam veterans.		
16. PTSD	12	85
Specific Topics: Repeat of program #15.		
17. Outreach, Phase V	20	175
Specific Topics: PTSD Topics: Group therapy; couples/family counseling; correct PTSD treatment modalities; Gestalt therapy; PTSD research findings and follow-ups; initial assessment; differential diagnosis of PTSD; treatment of black PTSD veterans; case conferencing; case management and referral; clinical supervision; crisis intervention; disabled PTSD veterans; female PTSD veterans; treatment of Hispanic PTSD veterans; inpatient treatment of PTSD; legal, moral and ethical issues; substance abuse; women partners.		
18. Outreach, Phase IV	16	51
Specific Topics: PTSD and marriage/family; clinical assessments; individual counseling; interviewing PTSD veterans; psychopharmacology; family violence; crisis intervention.		

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
19. Treatment of PTSD	13	81
Specific Topics: Overview of PTSD; use of individual therapy; use of group therapy; family therapy; crisis intervention; rap and support groups.		
20. Treatment of PTSD	13	72
Specific Topics: Repeat of program #19.		
21. Operation Outreach Conference	10	77
Specific Topics: Readjustment counseling for the PTSD veteran; individual, group and family therapy; crisis intervention; stress management.		
22. Family Therapy: Its Applications	2	75
Specific Topics: Special consideration in family therapy for the PTSD patient.		
23. Family Therapy: Its Applications	2	47
Specific Topics: Repeat of program #22.		
24. Family Centered Intervention for PTSD Veterans	12	126
Specific Topics: Understand basic components of PTSD; understand ways in which PTSD can interact with family problems; initial intake interview with PTSD family; screening/selecting families likely to benefit; family treatment planning and evaluation.		
25. PTSD	16	56
Specific Topics: 1. Historical aspects of Vietnam War and Era. 2. Importance of pre Vietnam character. 3. Effect of Vietnam experience on psycopathology. 4. Recognition and treatment of acute, chronic and delayed PTSD.		

	PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
26.	Integrated Approach to Readjustment Counseling Service	21	60
	Specific Topics: PTSD in the outreach program; outreach and readjustment techniques for PTSD; designing services for women Vietnam veterans; PTSD in minority veterans and family; PTSD program administration.		
27.	PTSD: PHE Model	24	111
	Specific Topics: Multidisciplinary treatment of PTSD; planning hospital based plans for PTSD; identify and clarify PTSD treatment team roles and functions; establish treatment plans.		
28.	PTSD	12	30
	Specific Topics: Overview of PTSD: combat stressors; diagnosis, assessment, adjudication; role of Veteran Outreach Center and VAMC; psychotherapy for combat veterans; treatment modalities, management disorders; female veterans with PTSD.		
29.	PTSD Mini-Residency	24	5
	Specific Topics: Psychiatric update on PTSD; clinical practicum on diagnosis and treatment of PTSD veteran and family; and related issues of drug abuse, sleep disorders, anger and hostility; treatment modality and choice of therapies.		
30.	PTSD Mini-Residency	30	1
	Specific Topics: Repeat of program #29.		
31.	MD #28 PTSD Update	16.5	44
	Specific Topics: Advances in diagnosis and treatment. Issues in psychopharmacology; crisis intervention, substance abuse.		

PROGRAM TITLE	LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
32. Reaching the Person in Crisis	2.5	42
Specific Topics: The assaultive patients: treatment procedures and dealing with anger and hostility and the Vietnam veteran.		
33. Reaching the Person in Crisis	2.5	58
Specific Topics: Repeat of program #32.		
34. Dealing with Stress Disorders Among Vietnam Veterans	13	49
Specific Topics: Combat stress; uniqueness of Vietnam war; self awareness and attitudes of staff toward Vietnam veterans; intervention and treatment approaches.		
35. Dealing With Stress Disorders Among Vietnam Veterans	12	47
Specific Topics: Review of PTSD; discussion and workshop on clinical experiences in the management and treatment of PTSD.		
36. Training for Operation Outreach	2.5	26
Specific Topics: Stressors and reaction to Vietnam combat.		
37. Training for Operation Outreach	3	27
Specific Topics: Historical overview of combat stress; anger and violence of Vietnam veteran; stressors and reactions to combat.		
38. PTSD and the Vietnam Veteran	8	65
Specific Topics: Overview of Vietnam experience; referral precedures; adjudication; clinical perspective of Vietnam experience; impatient treatment programs; Veteran Outreach Center programs.		

PROGRAM TITLE		LENGTH OF PTSD COURSE IN HOURS	# TRAINEES
39. PTSD Conference		7	54
Specific Topics:	Staff sensitization to the Vietnam veteran and their problems; assessment and diagnosis of PTSD; differential diagnosis; treatment approaches; new trends in PTSD patient management.		
40. PTSD		7.5	20
Specific Topics:	Diagnostic procedures; research on the combat Vietnam veteran; substance abuse; clinical treatment; referrals and services.		

TIME MANAGEMENT, EVALUATION, AND FUNCTION OF OPERATION OUTREACH VET CENTERS BY CENTER AND REGION

A paper presented to Operation Outreach
at the Regional Coordinators' meeting
Washington, DC, June 28 - 30, 1983.

Richard Stille, M.A.
Tom Scarano, Ph.D.
Dave Kaliher

Running Head: Center Function

INTRODUCTION

As a result of the realization that a significant number of Vietnam veterans were experiencing long-term problems associated with military duty in Vietnam, the US Congress authorized the VA to establish the Readjustment Counseling Program with Public Law 96-22 passed in 1979 and to continue the program with Public Law 97-72 in 1981. The program established 136 "Vet Centers" and satellites nationwide. These Centers were established in storefront locations outside the existing VA facilities, involved less paperwork and "red tape" than normal VA visits, and utilized a case finding approach to seek out and engage veterans in the community (Department of Medicine and Surgery, Veterans' Administration, 1982; Jacoby, 1982).

Because of the overwhelming need for services, the Centers were established on a direct service priority with the assistance of existing VA facilities. The Centers were organized around six regional areas and were established in both urban and rural locations. They are set up as small service delivery units generally staffed by four member teams. Major objectives of the program include readjustment counseling, outreach leading to identifying and engaging veterans in need of services, referral, facilitating use of VA facilities, and follow up (Jacoby, 1982).

The success in establishing Centers quickly and in providing quality services has been noted in numerous newspaper articles and in Congressional hearings (VA Vietnam veterans' readjustment counseling program, 1981; Miller, 1983). Formal evaluation of program function was not instituted, however, until a committee of staff members met in Salt Lake City in July, 1981 (Operation Outreach, 1981). The focus of evaluation in the Salt Lake City meeting was performance/productivity standards. The committee was able to set standards for number of new clients and number of visits, but was unable to arrive at criteria for follow up, number of groups, community education, collateral visits, outreach, or client satisfaction. They did, however, recommend that further investigation be conducted. Of special interest was the issue of differential functioning of urban vs. rural Centers. This investigation was conducted by Stille, Scarano, Christopherson, and Kaliher (1983) in a report accompanying this research.

During the last year, with the program beginning to prove itself as a professional counseling service, a realization developed among Operation Outreach staff that it would strengthen and benefit the credibility of the program to more thoroughly evaluate Vet Center functioning. As with any professional service, it is preferrable to thoroughly evaluate and assess the professional functioning of a program internally in order to prevent the loss of autonomy associated with external evaluation. There was also a feeling expressed that the program is functioning successfully at a high level of professional competence with high client satisfaction and that this success should be evaluated and documented.

As a result of a lack of previous research in the area, maturation in the program, and increasing requests for thorough evaluations, VACO Readjustment Counseling staff requested of the authors that they design the present research project. To aid in defining program objectives and future directions, we felt that an evaluation of the program as it functioned now was essential.

Because of the lack of previous research in this area, we were unable to define specific hypotheses. We did feel that it was important to define and measure the accomplishment of as many specified goals of the program as possible, as well as assessing those areas of functioning necessary to administer Centers. We also felt ~~it~~ would be of interest to see if these areas fell into logical groups of functions and to assess whether there was a difference between the six regions on these functions. Since we had no preset notions of how these differences might occur, it was not possible to present any prior hypotheses. The present research thus represents an examination of data gathered based on guidelines and objectives without a clear theory as to how Centers should be functioning or what differences might be expected. The purpose of the present research is to evaluate present functioning in order to provide data for further assessment and to generate future research on program functioning.

METHODS

Instruments

In an associated research project Stille, Scarano, Christopherson, and Kaliher (1983) developed two research questionnaires. The first questionnaire (Q1) consisted of 31 questions concerning rural/urban distinction, location, population, outreach to clients, and time involved in satellite supervision, contract fees-for-service, staff meetings, time off work and staff size (See Appendix A). The second questionnaire (Q2) consisted of 46 questions based on Operations Outreach's most recent Program Guide (Department of Medicine and Surgery, Veterans' Administration, 1981). The questions concerned time spent on assessment, review, follow up, types of counseling and outreach employed, time spent with VA and community resources, administrative issues, direct service counseling time, extra staff, research and teaching (See Appendix B). Both questionnaires were based on high face validity with a realization of the limits of self-report data.

Sample

The two questionnaires were mailed separately (Q1, then Q2 three weeks later) to every Vet Center and Vet Center satellite in the United States. The return used for statistical calculation from Q1 was N = 106 with some statistical procedures performed on the first N = 73. All procedures performed were replicated with the N = 106 data set. The return used for Q2 was N = 109 with preliminary analysis performed on data set of N = 100.

Statistics

All responses on both questionnaires were analyzed with a general statistical program to produce means, standard deviations, sums, etc. to describe general functioning of the program. On Q1 variables were grouped to produce estimates of total hours involved in travel, contract fees-for-service, meetings, trainings, etc.

On Q2 a factor analytic procedure was employed to explore and detect patterning of variables, to reduce the data set, and to construct new variables with high meaning value (Nie, Hull, Jenkins, Steinbrenner, and Bent, 1975). A principal components method of factor analysis was used with a varimax rotation (Helwig and Council, 1979).

An initial run limiting numbers of factors to those with associated eigenvalues $>$ 1.0 yielded twenty-four factors. A second analysis was then performed with a set limitation of four factors. Scores derived from these factors were then employed as new variables in both MANOVA procedures and univariate ANOVAs by region and rural/urban distinction.

RESULTS

Descriptive analysis of time function

When a client first enters the Vet Center she/he spends, on the average, one hour and twelve minutes in an assessment interview ($\bar{X} = 1.179$ hrs., $s = .529$). Eighty-three percent of Vet Centers use an intake form. Write-ups of these assessments generally take thirty-five minutes ($\bar{X} = .576$ hrs., $s = .288$). Less than 15% of Centers use standard psychological tests (MMPI, 16PF, etc.) during assessment ($\bar{X} = .147$, $s = .356$). From this interview, approximately 58% ($\bar{X} = .578$, $s = .496$) of Centers develop written treatment plans, and these plans are reviewed approximately every forty days ($\bar{X} = 1.303$ mos., $s = 1.543$).

Although the program defines .3 FTEE as direct service time available to team leaders, in reality .5 FTEE is spent on direct service time ($\bar{X} = 81.798$ hrs. per mo., $s = 45.842$). Counselor/technicians should be spending .6 FTEE direct service time, but are actually spending approximately 70% of their time on direct service ($\bar{X} = 117.284$ hrs. per mo., $s = 37.775$). Clerk/counselors are generally expected to account for .3 FTEE but actually spend approximately 14% of their time in direct service ($\bar{X} = 22.752$ hrs. per mo., $s = 31.296$).

Although Operation Outreach is cited as an innovative program, the main counseling modality that clients are referred to is individual. Approximately 60% of all clients are seen in individual counseling ($\bar{X} = 60.826$, $s = 24.819$). Group counseling is utilized by approximately 35% of clients ($\bar{X} = 35.294$, $s = 21.859$). The less traditional modes of family therapy and couples counseling are only used by about 10% of clients who come to the Centers ($\bar{X} = 9.624$, $s = 9.166$; $\bar{X} = 11.183$, $s = 10.461$, respectively). Approximately 15% of clients are referred elsewhere ($\bar{X} = 14.596$, $s = 12.407$).

Contract fees-for-services has been described as a "mixed blessing" by staff in the program (Miller, 1983). Although some Centers have been overwhelmed by contract fees-for-service (max. = 153 hrs. per mo.) the average amount of time a Center spent was approximately 15 hours per month ($\overline{X}$ = 15.248 hrs. per mo., s = 12.584).

Satellites have also been noted as a supervisory and administratively difficult arrangement. The seven Centers who had attached satellites averaged 2382 miles of travel per year to their satellites, or approximately 47 hours a year of travel time per Center. In addition, each Center averaged 95 hours per year in supervision time at the satellite.

The field of outreach was examined in four ways; 1) presentations or talks; 2) methods of contacting vets; 3) efforts to reach minority vets; and 4) rural outreach efforts. A Vet Center spends an average of 12 hours per month giving talks, presentations, interviews, in-services and other community education projects ($\overline{X}$ = 12.064, s = 8.199).

Speaking engagements, posters in stores, public service announcements, and media interviews are the most popular methods to outreach to vets ($\overline{X}$ = .927, s = .262 speaking; $\overline{X}$ = .853, s = .356 posters; $\overline{X}$ = .807, s = .396 psa; $\overline{X}$ = .807, s = .396 interview). Fairs and other shows, letters to vets, and coasters and matchbooks are also popular methods used by about half of the Centers ($\overline{X}$ = .679, s = .469; $\overline{X}$ = .523, s = .502; $\overline{X}$ = .550, s = .5, respectively). Less popular methods were calling vets and bus posters ($\overline{X}$ = .339, s = .476; $\overline{X}$ = .248, s = .434).

In the last year Readjustment Counseling has put special emphasis on outreach to hard to contact and engage groups, including women veterans, and significant others. In actual practice, however, only about half of the Centers have programs planned or implemented to outreach to these groups.

Over 75% of Centers have some form of outreach to significant others ($\overline{X}$ = .761, s = .428). Over 60% of Centers have outreach programs to minorities ($\overline{X}$ = .642, s = .482). Programs to reach women veterans are occurring in just over half of the Centers ($\overline{X}$ = .532, s = .501) and to handicapped vets in only about 40% of Centers ($\overline{X}$ = .404, s = .493).

Rural outreach efforts are more thoroughly detailed in an accompanying research paper (Stille, Scarano, Christopherson, and Kaliher, 1983). Rural Centers travel an average of 13,593 on both client visits and outreach per year and spend an average of 265 hours per year on outreach. This also involves an average of 25 overnight trips per year. Over 10,000 clients are currently seen further than 40 miles from Vet Center locations by Vet Center staff.

Another important function of Vet Centers is to develop relationships and interact on a professional basis with the parent VA facility and other community agencies and veterans' organizations. Vet Centers spend an average of 13 hours per month ($\overline{X}$ = 13.101, s = 9.712) working with professional resources within the VA system. They spend another ten hours per month interacting with local mental health professionals ($\overline{X}$ = 9.771, s = 7.714). They spend an average of eight hours per month with veterans' organizations ($\overline{X}$ = 8.330, s = 6.199) and six hours with local Congressional offices ($\overline{X}$ = 5.606, s = 4.168). This totals an average of 36.8 hours per month devoted to professional interactions on behalf of veterans.

Administrative time is also a major block of time in Vet Center functioning. Part of this time is spent on maintaining favorable relationships with VA parent facilities and interacting with VA support resources, such as supply, personnel, engineering, medical administration and support services. Vet Centers spend an average of 16 hours per month ($\overline{X}$ = 16.248, s = 11.937) with their VA parent facility and 13 of those hours with VA support resources ($\overline{X}$ = 13.101, s = 9.712).

Personnel areas, including employee supervision, counseling supervision, and performance evaluations, take approximately 16 hours per month ($\overline{X}$ = 14.037, s = 11.485 hrs. employee and counseling supervision per mo.; $\overline{X}$ = 18.385, s = 16.628, hrs. per year performance evaluations). Over 80% of Vet Center team leaders have scheduled counseling supervision meetings with their technicians ($\overline{X}$ = .826, s = .381).

Other administrative issues include managing Vet Center budgets and periodic reports. The average Vet Center team leader spends approximately nine hours per month on budget matters ($\overline{X}$ = 8.853, s = 6.584) and over 80% of Vet Centers maintain some sort of running budget ($\overline{X}$ = .835, s = .373). Periodic reports generally require about 22 hours per year of team leader time, or just under two hours per month ($\overline{X}$ = 21.743, s = 18.173).

Vet Centers spend an average of nine hours per month devoted to staff meetings and another nine hours per month are spent at trainings ($\overline{X}$ = 320.114 hrs. per year / 12 ÷ 3 team members = 8.89; $\overline{X}$ = 311.19 hrs. per year / 12 ÷ 3 team members = 8.64). These activities for team leaders, result in .64 available time for administrative matters. Although this and direct service time add up to more than 1.0 FTEE time, the average Vet Center employee works approximately 52 hours per week ($\overline{X}$ = 51.954, s = 10.777).

Although Vet Center teams are generally composed of four staff members, the average Vet Center has approximately ~~27~~ (13·14) part & full time available personnel. These personnel include volunteers, work-study students, DVOP's, and interns and practicum students. Over 80% of the Centers ($\overline{X}$ = .826, s = .381) use volunteers with an average of 3.358 volunteers per Center (s = 4.147). Almost 90% use work-study students with the average being 3.092 students per Center (s =

2.406). Eighty percent ($\overline{X}$ = .807) of Vet Centers have a DVOP who averages about 16 hours per week ($\overline{X}$ = 15.991, s = 16.477). Only 42% ($\overline{X}$ = .422, s = .496) of Vet Centers have either interns or practicum students and those Centers which do have them average 1.39 students per Center.

Research and teaching have become important adjuncts to Center functioning, especially at urban Vet Centers (Stille, Scarano, Christopherson, and Kaliher, 1983). This is still a new area, however, with only approximately 28% of Centers ($\overline{X}$ = .284, s = .453) involved in research projects, while over 45% have plans for future projects ($\overline{X}$ = .459, s = .501). Those involved in research generally spend about eight hours a month at it ($\overline{X}$ = 7.74). Twenty-three percent of Vet Center team leaders are involved in some sort of teaching ($\overline{X}$ = .229, s = .422) and spend about eight hours a month on it ($\overline{X}$ = 8.4).

Factor analysis

To reduce the data set and detect underlying patterns within the variables, Q2 was factor analyzed using a principal factors method with a varimax rotation. An initial run limiting factors to those associated with eigenvalues $>$ 1.0 yielded twenty-four factors. A decision was made to limit the set to four factors and these four factors were associated with eigenvalues of; Factor 1 = 7.207; Factor 2 = 4.462; Factor 3 = 4.339; Factor 4 = 3.472.

Examination of the beta weights associated with each factor by each variable led to logical assignment of names to each factor representing areas of Vet Center functioning. The first factor was associated with interactions with VA and mental health facilities, outreach, supervision, administrative concerns, and overall work time and was named Team Leader Administration Time Factor.

The second factor extracted was positively associated with direct services including assessment, group counseling (but not individual), outreach to minorities, use of practicum students, and research activities, and negatively associated with interactions with the VA and administration and was termed the Direct Service Factor.

The third factor was associated with thorough assessment but with negative loadings on direct service time with strong loadings on use of VA services and was labeled the Professional Interactional Factor.

The fourth factor was associated with high use of extra personnel and high involvement in research and teaching activities and was termed Expanded Professional Interest Factor (Stille, Scarano, Christopherson, and Kaliher, 1983).

Statistical comparisons

Three groups of statistical comparisons were run comparing rural/urban designation by factor, region by factor, and region by individual variables from Q2. The first comparisons, rural/urban by factor, were described in an accompanying paper (Stille, Scarano, Christopherson, and Kaliher, 1983).

On the first two factors, Team Leader Administration Time and Direct Services, there were no significant differences ($F = .46$, $p > .8079$; $F = 1.34$, $p > .2531$). On the third factor, Professional Interaction, there was a significant difference among regions ($F = 4.69$, $p > .0007$). A closer examination of the plot produced of region by Professional Interaction suggests that this was due to low Professional Interaction levels in regions one and two and high levels of Professional Interaction in regions five and six.

A significant interaction was also found on factor four, Professional Interest, by region ($F = 2.82$, $p > .02$). Examination of region/factor indicates that region five and region six were low on this factor while region two and four were high. Much of the variance in this interaction was accounted for by rural/urban by factor with rural areas unable to participate in professional interest because of lack of resources.

In using univariate techniques to examine a number of interactions in one set of research, adjustments would normally be made to provide for an overall experimentwise error-rate (Glass and Stanley, 1970). However, without defining a specific hypotheses a liberal decision point was employed using a cut-off of $p > .03$ per analysis. Using this criteria, four significant interactions were found.

A significant difference was found as to whether Vet Centers by region used intake forms or not ($F = 3.41$, $p > .0071$). Of those Centers responding from regions three and four, 100% used intake forms, 86% of the Centers in regions one and six use forms, 66% of region two, and 60% of region five Centers use forms.

Time spent utilizing VA resources differed by region ($F = 2.9$, p .0174). Regions two, five, and six had a high level of interaction with VA resources such as psychology, psychiatry, CDU's, etc. while region one and four tended to spend very little time with VA resources.

A major difference was also found on amount of time devoted to research ($F = 3.08$, p .0126). Most of this variance was accounted for by high levels of research in region five and partially by region six.

Overall weekly time spent on Operation Outreach business also differed by region ($F = 2.68$, p .0258) with staff in regions one, five, and six devoting the most time.

DISCUSSION

At the request of Readjustment Counseling Service Central Office staff, the authors undertook the present research to examine Vet Center functioning in terms of time management, rural/urban differences, regional differences, and outreach methods in order to establish baseline data to generate professional program evaluation and to generate future research on the program.

A previous project, using the same instruments on the present research, was undertaken to define rural/urban differences (Stille, Scarano, Christopherson, and Kaliher, 1983).

The assessment process in a Vet Center generally takes one and three-quarters hours including interview and write-up. Eighty-three percent of Vet Centers have a standard interview format that they use, while less than 15% use psychological tests as part of first assessment.

A finding of particular interest is that of amount of direct service time actually spent by both team leaders and counselors as compared to program requirements of direct service time. In both cases actual direct service time was much higher, with team leaders spending .5 FTEE on direct service and counselors spending .7 FTEE.

Individual counseling is the primary mode of service to clients with 60% of all clients seen in individual counseling. Thirty-five percent are seen in groups, which has generally been noted as the most effective treatment for Post-Traumatic Stress Disorder (PTSD). Of concern to the authors was the small amount of clients referred to couples counseling and family counseling and the authors would suggest more training of Vet Center staff in these modalities as many authors have suggested that PTSD has profound effects on the family and that family dynamics may work to maintain PTSD symptoms in spite of treatment.

Most outreach in Vet Centers is done by giving talks or presentations and by using the media through psa's and interviews. The findings on special outreach efforts to hard-to-reach groups were also unexpected, especially with women veterans and handicapped veterans and it is hoped that new efforts already begun by the program to increase awareness of handicapped and women veterans' issues will lead to increased outreach efforts.

A pleasant finding by this study was the extent to which Vet Centers have undertaken professional interactions with VA mental health, community mental health, veterans' organizations and Congressional offices. Because a large part of the philosophy and foundation of the program is based on a community psychology model, it is pleasing to see that in fact the program appears to be quite successful in that modality.

Administrative tasks in the Vet Center take 64% of the team leaders' time as well as a good deal of technician time. With multiple job responsibilities and a large amount of time devoted to direct service, the average Vet Center team leader or counselor spends approximately 52 hours per week on Center business. This represents over 25% additional time donated to the program and speaks highly of the devotion to the goals of Operation Outreach and the high level of responsibility of employees in accomplishing necessary tasks.

Research has become an important adjunct to Center functioning and our results suggest that research generated from the Vet Center level will almost double in the next year.

After factor analysis, the four primary retained factors were used in an analysis to compare regional functioning. The four factors were labeled; 1) Team Leader Administration Time; 2) Direct Service; 3) Professional Interaction; and 4) Expanded Professional Interest. Comparisons of region by factor suggested that regions five and six tended to have more professional interactions but were involved in less expanded professional interests. Part of the explanation for this finding may be found in the strong relationship between high professional interaction and less expanded professional interests found in rural vs. urban Centers. Regions five and six have the highest percentage of rural Centers in the nation. In a similar finding regions five and six, in addition to region two, had higher levels of interactions with VA resources, a strong variable in the Professional Interaction factor.

An unexpected finding was the high level of research done in regions five and six, because they had rated low on the Expanded Professional Interest factor.

Although examination of the program appears to have produced valuable results with quite a few unexpected findings, comparison of derived factors by rural vs. urban distinctions appears much more valuable than comparison by region. The main findings of the project leading to future suggestions are that the program might benefit from even more emphasis on group, family, and couples counseling modalities. New efforts to increase awareness of women veterans' issues and handicapped veterans issues may improve outreach to these groups in the future. Noteworthy findings are the successful jobs that the Centers have done in a community networking approach which has not been recognized as yet and the growing amount of research being generated at the Vet Center level.

A finding of particular concern to the authors is the amount of time Vet Center staff devote to Operation Outreach, especially in direct service. Many issues have been raised about overproduction threatening quality of services, but program staff are aware that the need existing in the streets for the type of counseling Operation Outreach offers is unlikely to decrease. A suggestion of the authors is that the program examine the feasibility of increasing the average size of the Vet Center by one to two counselors per Center to prevent burn-out of the existing Operation Outreach staff.

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APPENDIX A

May 2, 1983

Dear Team Leader:

In an evaluation of distinctive factors differentiating rural from urban Vet Centers, 11RC has asked us to evaluate outreach travel and time, satellite supervision and contract fees-for-service supervision time. Would you take a few minutes and respond to our questionnaire and return it to us as quickly as possible. We understand that you have not kept accurate accounts for many of the questions we are asking. We would appreciate your most accurate guess or estimate in those cases. We appreciate your time and energy on this and will give you some feedback on our results.

1. Square miles of cachement area? __________
2. Vietnam era veteran population in cachement area? __________
3. Population of city Vet Center is based in? __________
4. Distance from parent VA facility? __________
5. Would you characterize your center as a:
   a) _____ Rural Center
   b) _____ Urban Center
   c) _____ Both
6. If you characterized your center as both are your clients:
   a) _____ mostly urban
   b) _____ mostly rural

(FOR THE ANSWERS BELOW, FIGURES SHOULD BE FROM OCTOBER 1, 1982 TO MARCH 31, 1983 EXCEPT WHERE NOTED)

7. Total miles traveled to see clients-located further than 40 miles one way from center. __________
8. Total hours spent traveling to see clients located further than 40 miles one way from center. (total miles travelled ÷ 50mph = total hours) __________
9. Total clients seen who live further than 40 miles from Center. __________

10. Number of overnight trips made to see clients who live further than 40 miles from Center. __________

11. Total miles travelled to supervise your satellite Center, if you have one. __________

12. Total hours spent traveling to supervise satellite. (total miles travelled ÷ 50 mph = total hours) __________

13. Number of overnight trips made to supervise satellite. __________

14. Total miles travelled for outreach trips (speaking to groups, interviews, inservices) further than 40 miles from center to attract out of town clients. __________

15. Total hours spent travelling on outreach trips. (total miles ÷ 50 mph = total hours) __________

16. Number of overnights made on outreach trips. __________

(THE NEXT SEVEN QUESTIONS REFER TO TEAM LEADER'S TIME IN HOURS FROM OCTOBER 1, 1982 TO MARCH 31, 1983 EXCEPT WHERE NOTED.)

17. Time team leader spends at satellite center, if you have one. __________

18. Time team leader spends with contract fees-for-service. __________

19. Time team leader spends on annual leave (use one whole year, April 1, 1982 to March 31, 1983, and divide by 2) __________

20. Time team leader spends on sick leave (use one whole year, April 1, 1982 to March 31, 1983, and divide by 2) __________

21. Time team leader spends in staff meetings. __________

22. Time team leader spends at workshops, trainings, etc. __________

23. Other than direct service time, are there other significant areas that cost you time that we haven't noted above?

AREA	TIME
__________	__________
__________	__________
__________	__________
__________	__________
__________	__________

(THE NEXT SEVEN QUESTIONS REFER TO TOTAL TECHNICIANS' TIME IN HOURS FROM OCTOBER 1, 1982 TO MARCH 31, 1983 EXCEPT WHERE NOTED)

24. Time technicians spend at satellite center, if you have one. __________

25. Time technicians spend with contract fees-for-service. __________

26. Time technicians spend on annual leave (use one whole year, April 1, 1982 to March 31, 1983, and divide by 2) __________

27. Time technicians spend on sick leave (use one whole year, April 1, 1982 to March 31, 1983, and divide by 2) __________

28. Time technicians spend in staff meetings. __________

29. Time technicians spend at workshops, trainings, etc. __________

30. Other than direct service time, are there other significant areas that cost you time that we haven't noted above?

AREA	TIME
__________	__________
__________	__________
__________	__________
__________	__________

31. Number on your team (total) __________

    a) Team Leader __________

    b) Outreach Counselor __________

    c) Clerk/Counselor __________

    d) Clerk __________

Thank you for your time and effort. We appreciate it.

Sincerely,	Sincerely,
RICHARD STILLE	STAN CHRISTOPHERSON
Team Leader	Team Leader
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APPENDIX B

May 24, 1983

Dear Team Leader:

This questionnaire is designed to provide input into the evaluation, productivity, and reporting procedures now being formulated by 11RC. In an effort to examine the things that we are supposed to be doing (goals and objectives) we feel that 11RC staff should have a reasonable handle on what we actually are doing in the field and on what areas we feel it would be valuable to evaluate.

The data we are asking you to supply will be used in a statistical analysis of Vet Center functioning. Responses are not anonymous, but your reply will not be used to evaluate your center in any way. I know that questionaires take a lot of your time, are exasperating when you're faced with other, more important demands. We feel that it is important for us to have a say in how we are evaluated rather than leaving it to someone else, and I hope you will take the time to respond.

Thank You.

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1. When a client comes into the Vet Center, what is the average time spent in the initial assessment interview?

0-1 hrs _____ 1-2 hrs _____ 2-3 hrs _____

2. Do you use a written format or intake form? Yes _____ No _____

3. How much time is usually spent, on the average, writing up an initial assessment?

0-1 hrs _____ 1-2 hrs _____ 2-3 hrs _____

4. Do you have any tests (MMPI, etc.) that you generally use on initial assessment? Yes _____ No _____

5. Do you generally make up a written treatment plan for each client?

Yes _____ No _____

6. If the answer to question 5 is yes, how often do you review that plan?

every 0-1 months _____ every 1-2 months _____ every 3-4 months _____

every 4-5 months _____ every 5-6 months _____

7. After a client has terminated, do you have follow-up procedures to see how they are doing (such as telephone calls, letters, etc.)?

Yes _____ No _____

8. What percentage of clients get assigned to :

a) individual counseling _____%
b) group counseling _____%
c) family counseling _____%
d) couples counseling _____%
e) referred elsewhere _____%

(This may add up to more than 100% as many clients may be in more than one type of counseling)

9. Which of these methods do you use to obtain clients?

_____ a) Solicit TV, newspaper, or radio interviews
_____ b) PSAs on TV, newspapers or radio
_____ c) Send out letters to vets in area
_____ d) Posters in stores, other agencies
_____ e) Calling vets in area
_____ f) Bus plaques
_____ g) Soliciting speaking engagements at local club meetings, agencies, etc.
_____ h) Coasters, matchbooks, etc.
_____ i) State fairs, auto shows, job fairs
_____ j) Other (please list)

10. How much time do and your staff spend on your relationship with Veterans Service Organizations in your area per month? (e.g. Legion, VFW)

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____
31-40 hrs _____ 41+ hrs _____

11. How much time do you and your staff spend per month on your relationship with community mental health centers in your area?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____
31-40 hrs _____ 41+ hrs _____

12. How much time do you and your staff spend per month on your relationship with your local congressional offices?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____
31-40 hrs _____ 41+ hrs _____

13. How many hours per month do you and your staff spend with your parent VA facility?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____

31-40 hrs _____ 41-50 hrs _____ 51+ hrs _____

14. How many hours do you and your staff spend with VA resources per month, such as psychology service, social work service, substance abuse programs, etc.?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____

31-40 hrs _____ 41-50 hrs _____ 51+ hrs _____

15. How many hours per month do you and your staff spend with VA support resources, such as supply service, personnel service, medical administtation, engineering service, support services, etc.?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____

31-40 hrs _____ 41-50 hrs _____ 51+ hrs _____

16. How many hours per month, on the average, does your staff spend giving presentations, interviews, in-services, and other community education projects?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____

31-40 hrs _____ 41-50 hrs _____ 51+ hrs _____

17. What GS ratings and under what categories are your:

a) Team leader GS _____ category _____

b) Outreach Technicians or Counselors GS _____ category _____

c) Clerk/Techs or Counselors GS _____ category _____

d) Clerk GS _____ category _____

18. How much time per month do you spend supervising your employees, including counseling supervision?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____

31-40 hrs _____ 41-50 hrs _____ 51+ hrs _____

19. Do you have scheduled counseling supervision times with your technicians?

Yes _____ No _____

20. How much time do you spend each year on performance evaluations for you and your employees? _____ hours

21. How much time do you spend each month on issues related to your Vet Center budget?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____
31-40 hrs _____ 41-50 hrs _____ 51+ hrs _____

22. Do you have a running budget? Yes _____ No _____

23. How much time do you and your staff spend on the contract fees-for-service program per month?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____
31-40 hrs _____ 41-50 hrs _____ 51-60 hrs _____
61+ hrs _____

24. How much time do you and your staff spend preparing monthly/quarterly reports per year?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____
31-40 hrs _____ 41-50 hrs _____ 51-60 hrs _____
61+ hrs _____

25. Do have any specific outreach efforts to:

a) women veterans Yes _____ No _____
b) Minority veterans Yes _____ No _____
c) Handicapped veterans Yes _____ No _____
d) Significant others Yes _____ No _____

26. Please describe briefly any answers marked yes under question #25.

27. What is the average number of hours you spend per week in direct service counseling clients? _______ hours

28. What is the average number of hours each of your technicians spends per week in direct service counseling clients? _______ hours

29. What is the average number of hours your clerk/counselor spends per week in direct service counseling clients, if you have one? _______ hours

30. How much time per month, on the average, do you spend in direct service time with clients who are not technically eligible for the program? (e.g. vets of other eras, vets in prison, etc.)

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____

31-40 hrs _____ 41-50 hrs _____ 51+ hrs _____

31. Do you use volunteers at your center? Yes _____ No _____

32. If yes to #31, how many? _____

33. Do you use work study students at your center? Yes _____ No _____

34. If yes to #33, how many? _____

35. Do you have a DVOP or other job placement person at your center?

Yes _____ No _____

36. If yes to #35, how many hours per week? _________ hours

37. Do you have practicum students or interns at your center?

Yes _____ No _____

38. If yes to #37, how many and from what disciplines? _____ (number)

Disciplines: _______________________

____

____

____

39. Do you or your staff generally travel further than 40 miles from your center to see clients? Yes _____ No _____

40. If yes to #39, how many hours per month does your staff spend on this?

1-10 hrs _____ 11-20 hrs _____ 21-30 hrs _____

31-40 hrs _____ 41-50 hrs _____ 51-60 hrs _____

61+ hrs _____

41. Do you have research projects on Vietnam Veteran's issues ongoing at your center? Yes _____ No _____

42. If yes to #41, how many hours per month do you or your staff spend on this? 1-10 _____ 11-20 _____ 21-30 _____

31-40 _____ 41-50 _____ 51+ _____

43. Do you have any research projects planned for the future?

Yes _____ No _____

44. Do you or your staff have any teaching responsibilities at the V.A. or local college/university in conjunction with your job? Yes _____ No _____

45. If yes to #44, how many hours per month do you or your staff spend teaching? 1-10 _____ 11-20 _____ 21-30 _____

31-40 _____ 41-50 _____ 51 + _____

46. How many hours per week would you estimate that you actually put in on Operation Outreach business?

1-40 _____ 41-50 _____ 51-60 _____

61-70 _____ 71-80 _____ 81-90 _____ 100 + _____

We are sure that we have missed many important areas of Vet Center functioning. Would you briefly describe areas we have missed in your center and the time associated with them? (Continue on reverse if necessary.)

Thank you for your patience and cooperation. We will have results back to you soon.

Sincerely,

RICHARD STILLE
Team Leader
Minot Vet Center (503)

APPENDIX C

Rural Vet Centers

Number	Center
118	Williston, VT
119	St. Thomas, RQ
121	Bangor, ME
122	White River Jct., VT
208	Huntington, WV
209	Elkton, MD
216	Morgantown, WV
218	Harrisburg, PA
306	Jackson, MS
403	Grand Rapids, MI
501	Cheyenne, WY
503	Minot, ND
505	Des Moines, IA
506	Fargo, ND
509	Billings, MT
511	Rapid City, SD
513	Omaha, NE
516	Sioux Falls, SD
601	Albuquerque, MN
603	Anchorage, AK
613	Reno, NV
626	Eugene, OR
629	Gallup, NM
631	Wasilla, AK
632	Kenai, AK

TIME MANAGEMENT FUNCTIONING OF RURAL VS. URBAN VET CENTERS: OUTREACH ACTIVITIES OF OPERATION OUTREACH

A paper presented to Operation Outreach
at the Regional Coordinators' meeting
Washington, DC, June 28 - 30.

Richard Stille, M.A.
Tom Scarano, Ph.D.
Stan Christopherson
Dave Kaliher

INTRODUCTION

The Veteran's Administration's Vietnam Era Veteran's Readjustment Counseling Program, known as "Operation Outreach" was begun in 1979 as a result of Public Law 96-22 and continued by Public Law 97-72 passed in 1981. The program established 136 "Vet Centers" and satellites nationwide in storefront type locations, staffed primarily by counselors who are Vietnam veterans, employing innovative counseling techniques and modalities to help Vietnam veterans complete post-war recovery and readjustment processes (Jacoby, 1982).

The Centers that were established are located in both urban and rural localities. Major objectives of the program include readjustment counseling, outreach leading to locating and engaging veterans in need of services, referral, facilitating use of existing VA facilities, and follow up (Jacoby, 1982).

The need for such a program has been so great that many locations have been unable to do more than provide direct service readjustment counseling due to a heavy influx of veterans requiring service. Other Centers, located in rural areas, have had to seek out isolated veterans in dire need of service who have, because of readjustment difficulties, chosen to move to farms or ranches away from population centers. These separate demands have led to very different methods of functioning with different time requirements on rural and urban staffs.

Because of the nature of the program many innovative techniques in community psychology have been developed within the last two years. Outreach to minorities, reservations, rural areas, inner cities have all been more successful than most government programs.

As the program matured a realization developed that evaluation of the program was essential if Operation Outreach was to justify its continued existence. To this end, a panel of program officials and Vet Center team leaders met in Salt Lake City in July, 1981 and published a report establishing productivity standards in September, 1981 (Operation Outreach, 1981). Much of the discussion of this paper centered around the "primary goal" of Vet Centers and attempted to define this goal and develop standards from the goal. The standards were based on the goal:

> To provide quality readjustment counseling services of a direct nature to the greatest number of Vietnam veterans possible.

When these standards were set no distinction was made between rural and urban Vet Centers, Vet Center population base, or differing needs for time consuming outreach efforts. Productivity standards were based on size of team, assuming that all counselors should have .6 FTEE available for direct service whether they were in an urban or rural Center. In addition, a number was designated for new clients and visits for all Centers regardless of population density.

Although there were many oversights in perception of differential functioning in the Salt Lake City position paper, no response was made to the standards set because there was no impact attached to the numbers and no feedback was received concerning over- or under-producing or reporting of these figures until a 1982 meeting of 11RC (Readjustment Counseling) staff and regional coordinators. During this meeting regional coordinator staffs were asked to examine productivity reports and determine why some Centers were not meeting established criteria. The focus on productivity standards led to a general debate in the field on the process and function of Vet Center evaluation, especially among rural Vet Centers, who felt that outreach activities and concomitant time expenditure necessary for rural localities was being overlooked in the present evaluation process.

A number of proposed changes in either measurement of FTEE time or productivity standards were made by rural Centers. These proposals, however, did not answer a number of significant questions. The first question was how to define a rural Vet Center. Many Vet Centers were located in large urban areas but were also responsible for servicing large rural areas within their cachement area. Given a very small staff and a great demand for services, it seemed unlikely that these Centers would or could also service rural areas.

Another important question was how were rural Centers accomplishing outreach activities and, if they were doing so successfully, how could this be measured and evaluated? A final, but most significant, question was how much time did this outreach activity involve? Associated with this question was whether rural Vet Centers were able to spend as much time on other program objectives and administrative requirements as urban Centers.

These questions led to a number of hypotheses not previously examined by the program. They are as follows:

Hypothesis 1. Rural Vet Centers may be defined by the formula:

Square miles in cachement area (S) ÷ Vietnam Era veteran (VEV) population in cachement area (V) $= > 2$, and that the population of the city (C) that the Center is located in $= < 350{,}000$.

In other words:

$\frac{S}{V} = > 2$ and $C = < 350{,}000$ = Rural Center

Hypothesis 2. Those Centers defined as rural Centers will travel more miles and spend more hours to see clients who live in their cachement area but outside their home city. They will also travel more and spend more hours performing outreach activities to locate and engage veterans in need of services.

Hypothesis 3. Team leaders and counselors of rural Centers will have less available time to do direct service counseling than urban Center staffs because of the reduced time available as a result of heavier outreach loads. Further, team leaders will have less time for administrative and management tasks and will either (1) see less clients, or (2) do less administrative work.

In addition to the above hypotheses, it was felt that a general examination of Vet Center functioning, time management, and utilization of resources, to be used to develop a more refined evaluation procedure, was desirable. The research presented here attempts to address the above hypotheses and the problem of evaluation.

METHODS

Instruments

To test the above hypotheses two questionnaires were developed. The first questionnaire (Q1) consisted of 31 questions concerning size of cachement area, population, outreach to clients forty or more miles away, time required to supervise satellites if applicable, and other time management questions (see Appendix A). The second questionnaire (Q2) consisted of 46 questions concerning the functioning and time requirements of Vet Centers and was based on Operation Outreach's most recent Program Guide (Department of Medicine & Surgery, Veteran's Administration, 1982). Both questionnaires were based on high face validity with a realization of the limitations of self-report data. The second questionnaire was used in a further study of Vet Center functioning (Stille, Scarano, and Kaliher, 1983).

Sample

The two questionnaires were mailed separately (Q1, then Q2 three weeks later) to every Vet Center and Vet Center satellite in the United States.

The return used for statistical calculation from Q1 was N = 106 with some statistical procedures performed on the first N = 73. All procedures performed were replicated with the N = 106 data set. The return used for Q2 was N = 109 with preliminary analysis performed on data set of N = 100.

Statistics

All responses from both questionnaires were run through a general statistical analysis to produce means, standard deviations, sums, etc. as this was necessary to describe general functioning of the program. On Q1, to examine H1 two multivariate statistical procedures were performed, multiple regression analysis and MANOVA, to test the predictability of the model (Helwig & Council, 1979). In addition, univariate ANOVAs were performed to further examine the data. A similar procedure was used to test H2 and H3.

On Q2 a factor analysis procedure was employed to both reduce the data set and to create new factorial variables with high meaning value. Six factors were produced to examine logical consistency and four factors were retained to be used in both a MANOVA procedure and univariate ANOVAs (Nie, Hull, Jenkins, Steinbrenner, and Bent, 1975). These four factors were also retained for use in a second set of research hypotheses (Stille, Scarano, and Kaliher, 1983).

RESULTS

Hypothesis 1

To examine H1 a multiple regression analysis was performed with the dependent variable being whether or not a Vet Center self-reported that they felt they were a rural Center and the predictor variables being square miles in cachement area, Vietnam Era veteran population, and city population. The results of the multiple regression procedure were $F = 7.927$, $p > .0002$.

To further examine this relationship, univariate ANOVAs were performed on each of the three dependent variables. All three yielded significant results accounting for experimentwise error-rate. With square miles as the dependent variable, results were $F = 6.75$, $p > .01$; with Vietnam Era veteran population as the dependent variable $F = 14.39$, $p > .0003$; and with city population $F = 7.08$, $p > .0096$.

To further examine this hypothesis, twenty-five Centers were examined that had either self selected as rural or were designated rural by the first part of the formula of H1, $\frac{S}{V} = > 2$. These Centers were then examined to see if they differred on either defining criteria or predictability of whether or not they conducted outreach activities. Using a significance factor of $p > .10$, both populations were not found to be significantly different except in city populations ($F - 8.5$, $p > .0018$). An examination of the raw data showed two Centers in metropolitan areas with large rural cachement areas who were doing rural outreach. These Centers were retained for use in further analysis as rural Centers.

Hypothesis 2

To examine the hypothesis that rural Vet Centers travel more to see clients and to do outreach, two MANOVAs were performed using self-reported rural nature and Vietnam Era veteran density as independent variables with miles to see clients, hours to see clients, numbers of outlying clients, numbers of overnight trips, miles travelled to outreach, hours on outreach, and number of overnight outreach trips. Results for self-report of rural nature in the overall multivariate test were significant with $F = 2.51$, $p > .0204$. With population density the results were close to significance with $F = 2.01$, $p > .0613$.

To further examine this data, ANOVAs with two independent variables, rural and density, across two levels were performed on each dependent variable. Accounting for experimentwise error-rate all analyses were significant except for miles and hours to do outreach, which were close to significance (Miles: $F = 3.82$, $p > .025$, Hours: $F = 3.17$, $p > .0463$). Significant interactions were: Miles to see clients, $F = 16.96$, $p > .0001$; hours spent travelling to see clients, $F = 14.53$, $p > .0001$; numbers of clients 40 miles from Center, $F = 4.21$, $p > .0175$; number of overnight trips to see clients, $F = 17.48$, $p > .0001$; number of overnight trips to outreach to clients, $F = 4.47$, $p > .0138$.

In addition, T-test procedures performed on the travel time to see clients variable from Q2 yielded $T = 3.9247$, $p > .0002$.

Hypothesis 3

To examine time available to team leaders and counselors of rural and urban Vet Centers, Q2 was factor analyzed using a principal components factors method and a varimax rotation method with the rural/urban variable from Q1 included. After an initial run limiting numbers of factors to those with associated eigenvalues > 1.0, which yielded twenty-four factors, a second analysis was performed with a set limitation of four factors. The variance explained by each of the four factors (eigenvalues) was: Factor 1 = 7.207; Factor 2 = 4.462; Factor 3 = 4.339; Factor 4 = 3.472.

Examination of the beta weights associated with each factor by each variable led to logical assignment of names to each factor representing areas of Vet Center functioning. The first factor was associated with interactions with VA and mental health facilities, outreach, supervision, administrative concerns, and overall work time and was named Team Leader Administration Time Factor.

The second factor extracted was positively associated with direct services including assessment, group counseling (but not individual), outreach to minorities, use of practicum students, and research activities, and negatively associated with interactions with the VA and administration and was termed the Direct Service Factor.

The third factor was associated with thorough assessment but with negative loadings on direct service time with strong loadings on use of VA services and was labeled the Professional Interactional Factor.

The fourth factor was associated with high use of extra personnel and high involvement in research and teaching activities and was termed Expanded Professional Interest Factor.

These factors were then used in this research in ANOVA comparisons with rural vs. urban Vet Centers as well as examining individual variables through univariate tests. On the first factor, Team Leader Administration Time, no difference was found between rural and urban Centers, indicating that both types of Centers spend an equal amount of time on administrative functions.

On factor two, Direct Service Time, a procedure comparing rural Centers by region indicated a significant interaction ($F = 4.07$, $p > .0011$), while examination of the data indicated that this was due to a highly significant difference between rural and urban Centers ($F = 17.73$, $p > .0001$). Closer examination of the raw data indicates, however, that the finding was the reverse of the hypothesis presented, with rural Vet Center utilizing significantly more time than urban Centers on direct service counseling.

Analysis of factor three, Professional Interaction, by rural/urban and region, yielded a significant result ($F = 4.47$, $p > .0005$). Examination of variance accounted for by rural/urban did not reveal a significant difference ($F = 3.37$, $p > .0694$).

Analysis of factor four, Professional Interest, in the same fashion as factors one, two, and three, yielded a significant F value ($F = 6.17$, $p > .0001$).

The rural/urban variable was highly significant ($F = 22.93$, $p > .0001$) and examination of the data indicates that urban Centers are more likely to be involved with professional interest activities than rural Centers.

Examination of univariate data using T-test procedures and accounting for experimentwise error-rate showed that rural Vet Centers did more individual counseling while showing no differences in other types of counseling. Team leaders in rural Vet Centers also performed more direct service duties than team leaders in urban Centers. Examination of raw data, including rural/urban time analyses, will be presented in the section below.

DISCUSSION

Of a sample of 109 Vet Centers, 25 were identified as rural Vet Centers. An examination of both self-report measures and outreach functions indicate that the formula expressed in hypothesis 1 is a valid formula to define a rural Vet Center. Rural Vet Centers are those Centers located in cities of populations less than 350,000 who are responsible for large cachement areas twice the size of their Vietnam Era veteran (VEV) population. The average square miles of cachement area for all Vet Centers is 26,011 square miles while rural Vet Centers service an average area of 62,434 square miles. The mean VEV population of all Centers was 77,036 while the mean VEV population of rural Centers is 23,689. The city a rural Center is located in has an average population of 98,210 as compared to the national average of 593,464. As noted in the results section all statistical analyses of these variables as predictors of rural vs. urban designation were significant.

Those Centers designated as rural service significantly more clients located 40 miles or further from their Centers. To do so they averaged 10,196 miles per year per Center and to outreach to identify clients 40 miles or further away they travelled an average of 3390 miles per year per Center.

In travel time alone this averaged 264 hours per year per Center. In addition, rural Centers averaged 25 overnight trips per year to see rural clients and to outreach them. The average rural Vet Center had 165 clients who lived further than 40 miles from the Center currently being serviced. In all of these areas Centers designated as rural were significantly higher than urban Centers.

As noted in the results section, analyses were performed to see if this additional requirement resulted in a loss of service in other modes to veterans. Factor analysis of time management in Vet Centers showed that rural Centers spent the same amount of time as urban Centers on administrative functions in the Center, suggesting that the administrative requirements of both types of Centers are about the same.

In an unexpected finding, rural Centers are shown to be spending more time in direct service to clients than urban Centers. Both types of Centers spent approximately equal amounts of overall time on Vet Center business per week so that it appears as though the time difference may be explained by the significant difference on the Professional Interest factor. Rural team members, separated from the stimulus of professional interests found in larger urban areas, tend to spend that time on outreach activities, while urban team members have more time to focus on research and teaching opportunities. This is especially true of team leaders in rural areas who spend a much larger amount of time in direct service than urban team leaders, more than likely due to the professional interests available to urban team leaders.

These results indicate that low population densities of rural Vietnam Era veterans by square miles of cachement area define an entirely separate method of Vet Center functioning than in high density urban areas. It also suggests that time necessary to identify and engage these vets produces different requirements of rural teams who are not as able to fulfill other professional interests and may lead to a higher "burn-out" rate among rural teams. Low density also suggests that productivity standards of new clients set for urban Centers are inappropriate while equal amounts of direct service time suggest that contact hours or visits may be a more appropriate measure of rural Vet Center productivity. In addition, rural Vet Centers should also be evaluated on those outreach efforts and client travel which distinguish them from urban Centers.

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December 19, 1983

Doctor Donald L. Custis
Chief Medical Director
Veterans' Administration
Washington, D. C. 20420

Dear Dr. Custis:

I have recently been advised that Senator Alan Cranston wrote to you expressing his concern with the Vietnam Veterans Readjustment Counseling Program, and especially the effectiveness of this program's contractor provided services.

As you know, my Subcommittee held field hearings concerning the quality and quantity of health care provided to veterans in the VA's six medical regions. Testimony received at these hearings, as well as observations made by Subcommittee Members at site visits conducted in conjunction with the hearings, strongly confirmed the value of the Readjustment Counseling Program in assisting those Vietnam veterans in need of this particular type of medical service. It is the consensus of the Members of the Subcommittee that this worthy program should be fully funded and staffed now, and additional planning for further expansion be included in the Fiscal Year 1985 budget request. At the same time, however, the Subcommittee has observed that the contract or fees for services program has served only a limited purpose as an interim means of augmenting existing Vet Center services during a time when the life of the program was restricted by two or three year authorizations. Despite the inherent problems in administering contract services, it is understandable that the VA was reluctant under these circumstances to make a formal commitment in resources, personnel and facilities to increase the number of Vet Centers and satellites.

It is also my belief that the VA's optional authority to implement contract services for readjustment counseling could continue to be useful under certain circumstances. But, I would hope that such services could be controlled, limited and administered in such a way that they would not conflict with services which could reasonably be provided by VA personnel or proposed and needed augmentation of the Vet Center Program itself. For example, contract services could still be effective in rural or remote areas or in those cases where an individual veteran cannot effectively utilize or benefit from services provided through a Vet Center. However, it has been our experience from hearings in Washington and in the field that, for the most part, these contract programs cannot compete either in cost, effectiveness or administration with the quality of services currently provided through VA Vet Centers. The problems of higher cost, adequate supervision, and training of contractor personnel were made very clear to us in all sectors of the country. From this standpoint, it is my opinion that the contract program in many respects has become a burden and a liability to the effective implementation of readjustment counseling services.

With program stability enhanced by the four year extension contained in Public Law 93-160, it appears appropriate to expand the staffing and funding for the Vet Centers themselves to improve the quality and quantity of services.

For this reason, I would strongly urge that during the present and proposed budget cycles, the VA could implement a reallocation of funds out of total monies earmarked for readjustment counseling to begin to phase back the contract services in order to transfer those funds for the establishment of additional Vet Centers. Could you please inform me of any action which has been, or could be, taken to accomplish this reallocation either with the VA, the Veterans' Affairs Committees or the Appropriations Committees. Also, has the VA sent any request to the Office of Management and Budget requesting augmentation of the program or additional FTEE to staff additional Vet Centers?

Also, would you please provide the Subcommittee with information concerning the number of applications or requests Central Office has received this year for new Vet Centers or satellite Centers? Additionally, please advise us how many new sites and FTEE, if any, have been approved as well as DM&S plans for additional sites for the next three years.

Would you also be so kind as to provide us with a copy of the response you make to Senator Cranston's letter of December 9, 1983.

Thank you for your continuing assistance.

Sincerely,

Bob Edgar

BOB EDGAR
Chairman, Subcommittee on
Hospitals and Health Care

FEB 22 1984

10B/RC

Honorable Bob Edgar
Chairman, Subcommittee on
Hospitals and Health Care
Committee on Veterans' Affairs
Washington, DC 20515

Dear Mr. Edgar:

Thank you for your letter of December 19, 1983 concerning the Vietnam veterans readjustment counseling program and the effectiveness of the fees/contract program.

We are pleased to learn that testimony received at your field hearings last year strongly confirmed the value of the readjustment counseling program. As you probably know, nearly 70,000 new Vietnam era veterans utilized the services of this program during fiscal year 1983. This represents an increase of 19,000 from the prior year. We do not foresee a decrease or leveling off of these numbers in the near future.

The fees/contract program, as established and further defined under Public Laws 96-22 and 97-22, has been utilized to extend services to veterans living in areas remote from vet centers as well as to assist with heavy caseloads and provide additional expertise not available in specific centers. We have never felt it was Congress's intent for the program to be merely an interim measure, but rather a device we can use to strengthen our capability of providing needed services to Vietnam veterans.

When the Readjustment Counseling program was extended, we convened a task force specifically charged with the development of an internal review process for the fees/contract program. Like you, we had become concerned that this program was especially vulnerable to fraud, waste and abuse. When the task force's criteria are finalized, the review will be conducted under DM&S's Systematic External Review Program.

In FY 1983, approximately $6.1 million was obligated for the contract program. We expect that expenditures for FY 1984 and subsequent years will remain at around $7 to 7.5 million, as the total number of contracts in effect has leveled off at around 500. Thus, it is unlikely that there will be a substantial increase in the number of visits by veterans to contract providers.

Readjustment Counseling Service has recently completed a review of the staffing needs of Vet Centers and is developing criteria for the enhancement of existing centers and the selection of new sites. We are evaluating various ways of funding additional and expanded centers, including seeking Congressional approval to reprogram excess funds from the earmarked fees/contract program and acquiring additional personnel ceiling to staff these centers. A listing of additional sites will be developed in case additional resources become available.

A growing number of Congressmen share your support and recognition of the fine work our Vet Centers are doing. During the last 18 months 44 members of Congress have requested the establishment of Vet Centers in their states and districts; another 24 members have focused on Vet Center staffing problems, such as selection of a Team Leader or Outreach Technician; another 5 letters have been received by our agency from concerned citizens relative to the location of future Vet Centers. These concerns will be considered as we prepare our list of sites for possible program expansion.

Also, in response to your request, we are furnishing a copy of the letter that we sent to Senator Alan Cranston regarding the status of the fees/contract program and related matters.

Thank you for your continuing interest in our readjustment counseling program.

Sincerely,

Signed by the Deputy CMD

DONALD L. CUSTIS, M.D.
Chief Medical Director

Enclosures

STATEMENT OF
STEVEN M. SILVER, Ph.D.
STAFF PSYCHOLOGIST
INPATIENT POST-TRAUMATIC STRESS DISORDER PROGRAM
VETERANS ADMINISTRATION MEDICAL CENTER
COATESVILLE, PENNSYLVANIA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

March 29, 1984

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify before you on my VA medical center's program for the inpatient treatment of post-traumatic stress disorder (PTSD). I am Steven M. Silver, staff psychologist for the inpatient post-traumatic stress disorder program at the Veterans Administration Medical Center, Coatesville, Pennsylvania. I have worked in the PTSD Program since it began more than two years ago. I am a consultant to the American Indian Working Group of the VA's Readjustment Counseling Service. Prior to joining the VA, allowing for time spent in various graduate schools, I worked in a community counseling and crisis intervention center in Ohio. All in all, I have worked as a counselor and therapist to Vietnam War veterans and their families since 1971. I am a veteran of the Vietnam War and served in Marine Fighter-Attack Squadrons 115 and 122 in 1969 and 1970. There are several comments I would like to make.

I think it is essential to include the families of Vietnam War veterans having PTSD as potential candidates for counseling services. My clinical experience over the past 13 years as well as a national research study I conducted have convinced me of the critical importance of such services, not only in terms of aiding the families, but also in terms of assisting the veteran to resolve his or her problems. The clinical experience and research of others, such as Dr. Charles Figley, support this view.

Within our PTSD Program at Coatesville, our staff has found that the veterans are not the only "walking wounded" coming out of PTSD. We now regularly involve family members in treatment, educative, and support services. Recently our social worker and clinical nurse specialist began treating those "significant others" whose partners were in our inpatient program.

As far as PTSD research is concerned, I have one note of caution. At the present time, the PTSD program at Coatesville would be unable to carry out any but the most passive kind of research. The reason for this is that our staff is stretched extremely thin providing services; to take on any kind of major research effort would run the risk of deteriorating therapeutic services. Caution, therefore, would have to be used regarding the imposing of research requirements unless there was sufficient trained staff to reasonably handle it.

Staffing is, of course, the critical issue. Our program has a psychiatrist, a psychologist, and a clinical nurse specialist on full-time status. CS 3 night [illegible] Our social worker and our nursing staff are expected to cover an additional ward. We have beds for 13 men and 2 women in our 4-month program. Apparently because of our reputation, we are receiving referrals from New England, New York, New Jersey, Delaware, Maryland, West Virginia, Ohio, Virginia, the District of Columbia, and, of course, from throughout Pennsylvania. Our waiting list is more than eight months long. It says something about our veterans that so many of them are willing to endure this wait, though I am deeply concerned about the fate of those who drop off and out.

As I prepared for this presentation, my co-workers repeatedly told me to make sure that I emphasized that sheer numbers of staff would solve nothing, that the critical need would be for competent and motivated staff. For most mental health professionals, competency in the treatment of PTSD would be facilitated by careful training both in skills and sensitivity. Further, because of the sensitivity of the Vietnam War veterans and the intensity of the work, the ideal would be to use only those staff who want to be involved.

Perhaps the experiences of our staff at Coatesville could serve to clarify these last few points. Our staff, individually or collectively, participates in at least one major education program a month--here I refer to teaching in national conferences, VA-sponsored training such as conducted at Regional Medical Education Centers (RMECs) Regional Phase Training for Vet Centers, and so on, as well as community education efforts. During these programs and in the course of our clinical work we have had many opportunities to exchange ideas with and listen to other professionals. We find somewhat surprisingly, there is still ignorance as to what PTSD is, how it is treated, and how it relates to the Vietnam War experience. It is reasonable that those who staff future programs be provided with the best training possible. Obviously, motivation cannot be trained into someone but it is possible to sensitize professional staff to the Vietnam veteran experience. We would urge, in the strongest possible terms, that this be done.

I would suggest that the experience of my program indicates that a positive outreach effort to particularly isolated and disadvantaged veterans is a very important component of any inpatient PTSD program. This obviously needs to be done in coordination with the excellent efforts of the VA's Vet Centers. Close cooperative relationships with the Vet Centers is a key requirement for the inpatient programs. Particular populations needing attention would include American Indian, Hispanic, and women Vietnam veterans.

In regards to female Vietnam veterans, the Coatesville PTSD Program has taken the position that relatively minor adjustments of physical plant should not be permitted to exclude women veterans from inpatient PTSD programs. In our experience, the problems involved in running a mixed male and female PTSD program have been insignificant; the positive benefits have been very great. I would suggest that it would be appropriate for all future PTSD programs to clearly pertain to all our Vietnam veterans--male and female.

A more general comment I would make is that the development of inpatient PTSD programs is not a simple procedure. Not only will competent, sensitive, and motivated staff have to be recruited and trained, there are other issues to deal with as well. Patient selection, diagnosing, and follow-up are very important. The programs should not be a "dumping ground" either for staff or patients and careful monitoring of their development should be an ongoing concern.

I would be happy to answer any questions you might have. Thank you for your attention.

STATEMENT OF
MR. FRED D. GUSMAN, M.S.W.
VIETNAM VETERANS TREATMENT UNIT
VETERANS ADMINISTRATION MEDICAL CENTER
MENLO PARK DIVISION, PALO ALTO, CALIFORNIA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

March 29, 1984

Mr. Chairman and Members of the Committee:

In 1977, a multidisciplinary task force conducted a survey of veterans hospitalized at the Menlo Park Division of the Palo Alto Veterans Administration Medical Center. That survey found that Vietnam veterans desired psychiatric services more specific to their special problems. In response, the task force was given strong and continuing administrative support for the implementation of such a special program.

Consequently, the Vietnam Veterans Treatment Unit was opened in 1978. In 1981, the program was expanded to its present 90-bed capacity and has generally maintained a full census ever since.

The Vietnam Veterans Treatment Unit is an inpatient psychiatric treatment program specifically designed to treat combat related post-traumatic stress disorder (PTSD). The patients treated cover a wide range of racial, ethnic, and socio-economic groups. They are residents of the northern California catchment area or of more distant places upon special request and approval. Fifty to seventy percent have a history of life-threatening depression. All are in acute distress in addition to manifesting varying degrees of PTSD symptomatology.

Goals and Assumptions

The mission: (a) to relieve acute psychological distress; (b) to restore the veteran to a maximal level of functioning within a minimal period of hospital; and (c) to reintegrate the veteran into the community.

The identity as a Vietnam veterans program underscores the positive identity of the Vietnam veteran and deemphasizes potential further stigmatization as a mental patient or behavioral deviant. In the program the veteran is encouraged to reexamine war experiences in the context of any conflicted decisions made there or since.

The turmoil in our country during the Vietnam war caused many of the combatants to feel that their heroism was meaningless and their nation uncaring. Defining the program as a Vietnam Veterans Center is a direct message that their contributions are valued and their suffering legitimate.

Description of the Program

The Vietnam Veterans Treatment Unit is a modified therapeutic community emphasizing self-help, peer support, and peer pressure principles within a grounded base of traditional psychotherapeutic modalities. The treatment helps the veteran "debrief" from the military experience and reconnect with the civilian world. Psychiatric interventions are highly specialized in the diagnosis and treatment of this psychiatrically ill population. The program employs a wide array of specific psychotherapeutic techniques, including psycho-analytically oriented individual and group psychotherapy, behavioral techniques, transactional analysis, Gestalt and hypnosis. Additionally, Social Work knowledge and skills are the basis for the program's "planned community" in which patients are assigned or achieve roles and functions which confer status, self-esteem and social usefulness. The program fosters a Vietnam veteran subculture so that patients can develop cohesive support (networks) both within the medical center and the outside community. Group approaches are emphasized because a major goal of the program is to foster the development of trust among members of the Vietnam veteran peer group.

A partial list of currently available therapeutic groups includes:

1. Community Briefing
2. Reflective Writing
3. Art Therapy
4. Active Lifestyles
5. Anger Group (introductory)
6. Conflict and Resolution
7. Primary Tension Reduction
8. Learning Lab
9. Anger Group (advanced)
10. Managing Wallness
11. Addictive Behavior
12. Death and Dying
13. Self-Confidence
14. Community Choral Group
15. Grad Group
16. Relaxation
17. Physical Conditioning
18. Community Sports
19. Minority Group
20. Ethics and Morals
21. Alternatives to Self-Medicating
22. Psychotherapy Group (A&B)
23. History of Vietnam-2500 B.C.-1984
24. Vietnam Focus (a war trauma group)
25. Vietnam in Perspective
26. Couples Group

Treatment is divided into three phases. Each phase requires 45 days. Many therapeutic issues, however, are addressed throughout the program and are not "phased." All phases deal with anger, interpersonal intimacy, minority concerns, sexual functioning, employment, and financial concerns.

In Phase One, newly-admitted patients seek the resolution of the acute crisis which may have brought them into therapy. There is a considerable amount of emotional catharsis as trust is built up between the veteran, the veteran's peer group and the staff. Matters outside the program are "cleaned up" which might interfere with the veteran's commitment to personal therapeutic work within the program.

Treatment starts where we find the patient. This often means dealing with an angry, depressed veteran who expects less than an even break and who is still living out the Vietnam trauma. In the group, "History of Vietnam" the veteran will begin to test the factual validity of some personal attitudes. In Vietnam Focus we deal directly with the individual's own personal "Vietnam." The veteran may experience an abreaction of emotion whose force and drama cannot be adequately described. Emotions come pouring out like pus from a lanced boil. These emotions are not secondary effects--feelings about the past--but primary affects--those experienced during the event itself. Such an abreaction is indistinguishable from a flashback or a spontaneously induced trance state. If the anxiety is managed effectively, the veteran is both "there" and "here." This therapeutic encounter permits the veteran to process the trauma and to reexperience a sense of belonging which may have been lost in the jungle. This acute phase of therapy usually takes less than several months, sometimes only weeks. It is the beginning of the process of "coming home." The veteran's "Vietnam" may become a source of inspiration and of renewed commitment to values and meaningfulness.

Phase Two patients are typically out of crisis and settled into the program. Patients with thought disorders and other psychiatric conditions require ing psychoactive medications have been appropriately diagnosed and medicated. Patients for whom combat-related experiences are not major factors in their suffering will have been referred to other treatment centers as indicated. During this phase neurotic projections of responsibility are discarded, not because they are totally invalid, but because they prevent personal growth. Coping skills are learned and, by the end of the phase, patients have developed solutions or alternatives to problems which have been delineated and will have mapped out plans for reintegration into society's mainstream.

Phase Three is devoted to psychosocial rehabilitation. Housing, income, relationships, employment, and educational opportunities are pursued. This is a hospital-to-community transitional phase for trying out the skills learned in the program. Veterans in this phase of the program serve as counselors in a crippled children's camp, volunteer in Big Brothers of America, and group workers in a local senior center. The patients also participate in the combat veteran choral group which has performed throughout California and in Washington, D.C. The community work done by the veterans and the national acclaim earned by the program both serve as therapeutic adjuncts to the building of a positive self-image.

Use of Medications

Psychoactive medications are of limited value in the treatment of PTSD and may act in furtherance of the individual's neurosis. The Librium/ValiumXanax/Serax family are subject to "alcohol-type" abuse and dependence and can be associated with worsening of depressive or dyscontrol behaviors.

Despite our attitude of concern and caution regarding the use of psychoactive medications in the treatment of PTSD, such medications are at times appropriate and necessary.

The program is especially careful in the prescription of addictive analgesics. PTSD patients seem to have less tolerance for certain kinds of pain and seem to demand excessive doses of analgesics to reassure themselves that their pains will not "ambush" them. In this regard, the program has noted a higher than predicted incidence of cluster migraines and lower back muscle spasms.

Organizational Support

From its inception the program has received active encouragement at the medical center level, the regional level and at the Central Office level. At the medical center level, clinical and administrative guidance and support have been provided by the Director, Chief of Staff (MPD), Psychiatry Service and Social Work Service. This sanction has resulted in provision of staff space and furnishings.

The Regional Director (Region 6), Mr. Dan Cooney, has met with the Program Director periodically and is working with him to develop a Vietnam Veteran Regional Demonstration Project. This project would include clinical care and teaching and research in the area of PTSD in the Western Region.

As the Central Office level, Dr. John Lipkin, Deputy Director, Psychiatric Service, has provided consultation and direction to the Program Director and has visited with the patients and staff at the Menlo Park, California, Veterans Administration Medical Center over the past two years.

Mr. John Fulton, Director of Social Work Service, VA Central Office, has provided guidance to the Program Director during several meetings both in Washington, D.C., and California.

This completes my formal statement, Mr. Chairman, I'd be pleased to answer any questions you may have.

STATEMENT OF
ARTHUR L. ARNOLD, M.D.
CHIEF OF PSYCHIATRY
VETERANS ADMINISTRATION MEDICAL CENTER
PHOENIX, ARIZONA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

March 29, 1984

Mr. Chairman and Members of the Committee:

My name is Arthur L. Arnold, M.D. I am Chief of Psychiatry at the Veterans Administration Medical Center in Phoenix, Arizona, and previously held the same position at Bay Pines, Florida, where in 1981 I established an inpatient/outpatient unit for the treatment of post-traumatic stress disorder (PTSD) in Vietnam combat veterans. I have also organized and conducted professional education in the diagnosis and treatment of PTSD in Vietnam veterans for various VA Regional Medical Education Centers (RMECs) around the country and at several scientific conventions of the American Psychiatric Association, and initiated the planning for a VA-sponsored collaborative research study on the treatment of PTSD in Vietnam veterans. As an officer of the National Association of VA Chiefs of Psychiatry, and a member of a VA-sponsored field task force, I have worked on Diagnosis-Related Groups (DRGs), including their relationship to the allocation of resources for treatment of PTSD in dedicated units. With Dr. Smith, also appearing before you today, I am a member of the Advisory

Committee on Readjustment Problems of Vietnam Veterans appointed by the Administrator of Veterans Affairs.

At Bay Pines in 1979 and 1980, I was aware that PTSD is a condition present in most Vietnam combat veterans being treated on my acute psychiatry wards. I also became aware, from reviewing medical records and discussing cases, that this was frequently not recognized and diagnosed or treated appropriately. It was common to find mutual antagonism between patients who were Vietnam combat veterans and members of the clinical staff. In 1981, 20 beds--half of an acute psychiatry ward--were designated for Vietnam combat veterans with PTSD with staff who were voluntarily reassigned from other multidisciplinary treatment teams. The initial specialized treatment program was primarily individual and group psychotherapy to bring out in the open and deal with the specific combat experiences which had so psychologically traumatized these men that they continued to produce profound guilt, grief, anxiety, alienation, and rage after more than 10 years. A little later, an outpatient treatment team was added to the program. From the start, we collaborated closely with the Vet Center. As the need became apparent, we added counseling groups for the wives and girl friends of the veterans, personal journal groups, alcoholism groups, selective use of medications, team sports, relaxation techniques and biofeedback, vocational assessment and counseling, and remedial basic education which was provided by the county adult education department.

Many of the veterans improved, some of them quite remarkably, but some of them only after many months or several readmissions. An obvious major factor in our success was the mutual support the Vietnam veterans on the unit provided to each other, like brothers. They demanded the best efforts, and encouraged endurance, courage, and the sharing of fears, grief, and remorse. They carried each other through nightmares and flashbacks, cried together, and learned to laugh again together.

It is an intensive treatment program, and it is hard on the staff. We had a bare minimum of the professionals needed, so there was not enough time to relax and support each other to ward off burnout. There was not the time needed to pursue their own further professional education in PTSD, let alone to do research. We recognized that other treatment modalities were needed, but no additional staff were available to provide it. There was not enough nursing staff to cover the unit on nights and weekends so it could be moved onto a separate ward.

The unit was filled to capacity continuously. Literally, we admitted the veterans with the most urgent problems from among those who were waiting the same day we had a discharge. We were barely able to accommodate the Vietnam veterans in our own immediate area, so without other units in Florida we needed to expand but were unable to because of the lack of additional staffing. We found the veterans' problems so deeply ingrained, after a decade of holding it all in, that treatment was a long process. The average length of stay was about five months. The turnover rate was not as high as for the rest of the acute psychiatric bed service, which had an average length of stay less than 20 days. In other words, we were able to treat only one-sixth as many veterans per year per bed on the PTSD unit as on the general wards. We received calls literally pleading for admission from all over the country where no specific PTSD treatment was available. On the basis of my experience addressing the issue of PTSD in Vietnam veterans, my major concern is the immediate need to provide appropriate treatment using known techniques--an expansion of the capacity to be responsive. Practical professional education should contribute to that end. In my view, it is important, but less urgent, that research be expanded. In other words, from my vantage point, the need is for many more comprehensive treatment units, rather than a few research and education centers with a few "teaching beds." Vietnam combat veterans with PTSD have needed our help for more than a decade. This is a here and now problem which is widespread. If we work together, we can meet their needs.

Mr. Chairman, this concludes my formal statement. I'll be pleased to answer any questions you may have.

Duke University
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NORTH CAROLINA

DEPARTMENT OF PSYCHOLOGY

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STATEMENT OF

JOHN RUSSELL SMITH
Incoming Director
Center for Trauma Recovery
VA Medical Center
Cleveland, Ohio

Before the Subcommitttee on Hospitals and Health Care
House Committee on Veterans Affairs
United States Congress

Washington, D.C.
March 29,1984

Statement of
John Russell Smith
March 29,1984

As one who spent several years involved in the efforts to recognize Post Traumatic Stress Disorders in the new psychiatric diagnostic manual and to assist in the development of the Vet Center program, I vigorously applaud and endorse the intent of HR 4833 to extend PTSD treatment services. The lack of sufficient services currently is a tragedy.While I am continually saddened by the desperate needs, I am also encouraged by the progress over the past decade. Having reviewed the literature of the past 120 years on this problem, I am well aware of the formidable challenges it has presented to many societies and the mental health professions. Slow as change seems to have been, the Vet Center program, VA PTSD units and civilian interest in PTSD are a direct result of and have accelerated the attention paid to traumatic reactions in the past decade. Many of us have come to see stress reactions and PTSD as the single most important service related mental health issue. This bill advances the possibilities for better and more widespread treatment. By placing emphasis on research and documantation of treatment efectiveness as well as professional education it makes likely useful applications in treatment of POWs, veterans of other eras, and other catstrophic reactions such as the Coalinga earthquake, and the Hyatt Regency collapse in Kansas City.

With respect to the bill itself, I have several suggestions for the Committee's consideration., detailed below:

620B.(a) Eligibility

Recommendation: The Committe consider broadening the eligibility to include -"any veteran who" - is determined by the Adminstrator to be suffering from service-related post-traumatic stress disorder.

620B. (c)(1) Where provided.

Recommendation: The Committee consider limiting the establishment of PTSD treatment units to not more than one per medical district.

620B.(c)(2) Education of Health Care Professionals

Recommendation: The Committee consider adopting this provision and consider supplemental funding for such education.

620B.(c)(4) & (d) Research

Recommendation: The Committe should consider adopting this provision and consider modest supplemental funding for such research.

Priorities and Supplemental Funding

620B.(a) Eligibility

Recommendation: The Committe consider broadening the eligibility to include -"any veteran who" - is determined by the Adminstrator to be suffering from service-related post-traumatic stress disorder.

Discussion: Recent initiatives to reevaluate the medical needs of POWs have uncovered numbers of POWs with continuing apparent PTSD realted problems. Professionals with PTSD expertise are increasingly being asked to consult in the treatment of these individuals. As in the case of Vietnam veterans with PTSD, these patients are not usually best treated on the general psychiatric wards where they are currently assigned. Specialized PTSD units could develop readily the capability for undertaking such efforts if tasked and funded to do so. Existing plans for such capability have been developed by the Cleveland VAMC in its Center for Trauma Recovery. Not only would Vietnam veterans, men and women, and POWs be treated but WWII and Korean veterans as well as though few veterans of Lebanon who have begun to appear for treatment. (See Appendix A)

620B. (c)(1) Where provided.

Recommendation: The Committee consider limiting the establishment of PTSD treatment units to not more than one per medical district.

Discussion: The proposed limitation of not more than 15 PTSD units may not be ofimmediate concern. Resources and trained staff may be an issue in limiting the numbers. But the discretion of the Adminstrator and the Chief Medical Director should not be so narrowly circumscribed. Better methods of accomplishing the intents of this section might be found.If limitations are to be sought, it seems more reasonalbe to make geographical rather than numerical restrictions. Since demand for these treatment services is already so high and the waiting lists so long, numerical restriction might result in demand for greater bed and patient loads at the limited number of facilities when clinical wisdom might suggest a cap on the number of beds and greater distribution.

620B.(c)(2) Education of Health Care Professionals

Recommendation: The Committee consider adopting this provision and consider supplemental funding for such education.

Discussion: This provision is especially apt at this point. Opportunities for mini-residencies and fellowships to study at existing PTSD units could be afforded and are included in the existing recommendations for the Cleveland Center. (See Appendix A) Staff from the existing units have participated in initial efforts by the RMECs to conduct such training. Amplification of these small efforts should be accomplished by close collaboration between PTSD units and nearby RMECs. Encouragement of diversity and scrutiny of several treatment strategies and combinations should be encouraged. No one model should yet be imposed or centrally directed. (See the further discussion of Priorities and Supplemental Funding.)

620B.(c)(4) & (d) Research

Recommendation: The Committe should consider adopting this provision and consider modest supplemental funding for such research.

Discussion: (See further discussion of Priorities and Supplemental Funding.) It is imperative that current treatment efforts begin to be well documented and outcome evaluations of various treatment approaches be undertaken. Current data on effectiveness and utility is inadequate. Scientific concerns as well as accountability demand that such efforts become an integral part of PTSD treatment units. Comparability of data and collaboration are also essential now. In addition basic research should be encouraged into the causes, diagnosis, social,cognitive and pshysiological correlates of the stress responses. Close collaboration on research means support for regular and continuing contact. To date, mechanisms for the encouragement of basic research, outcome evaluation and dissemination have been irregular and minimal. The National Institute of Mental Health may be providing more consistent research and outcome evaluation support on PTSD in veterans than the VA is currently able to provide. Some of the most distinguished VA researchers have obtained or are seeking NIMH support for PTSD research for projects whose funding has been discontinued by the VA. Since many of us regard PTSD as a area of principal concern as a service related problem, we are concerned about this situation.

Priorities and Supplemental Funding

The increased recognition of PTSD and related readjustment problems has created headaches for the VA as well as for Congress. Both the VA, its hospitals, its Vet Centers, and the Congress have faced escalating demands for funds and personnel to address these issues. For the VA, these demands have come at a time of increased pressures on an already strained hospitals budget. Special Congrssional appropriations created the Vet Center program to beginto meet those needs. Th program has been highly successful. But it has taxed the spiritual resources of its employees. And despite the budget controversies has undoubtedly strained the general VA budget in myriad indirect ways. And the time limited program has been extended due to the demand. More clients and new veterans have responded in past months than at any time since the inception of the program. Congress put muscle in its committment by allocating scarce resources to it. By doing so it indicated a willingness to follow through in the long haul with those who honored their committment to risk their lives when the nation chose a difficult mission. And the Vet Centers and PTSD profesionals responded. They shared the skills and knowledge gained with their veteran peers. Not only veterans have benefitted. Vet Center people helped the eathquake victims in Coalinga. PTSD experts who began with veterans, worked at Buffalo Creek after the flood, in Kentucky after the Beverly Hills supper club fire, and the Greenville, NC after the explosion.

But PTSD problems have not been entirely alleviated by the Vet Center program. Client loads are up. And the centers and hospitals continue to uncover numbers of the most troubled veterans. And the Vet Centers and the veterans rightly looked to the Medical Centers for help with the severe PTSD cases. POWs now being reevaluated in an outreach effort are frequently identified with PTSD problems. All of these veterans looked to the hospitals for a link. We needed a back-up system for the most serious cases. Hospitals have responded in various fashions. Some have denied the problems exist. Some have asserted that they would help if only resources were provided. A few have shuffled their own resources, their funds, and their people to begin PTSD programs at their own initiative. They have made the problem a priority in their own system. This legislation seeks to reward and assist their efforts.

But like most such programs, they are not designed in the ideal, with idea in mind o how best to accomplish the task. Rather, of necessity, thye juggle existing resources, carving out what they can to patch together a program. Most have been very successful with such limited resources. But they are short of staff. They lack integrated aftercare or outpatient resources. Therefore they keep their patients until they can be sure they will make it back on the street. They lack nursing staff. They have to cram clinical work into a short day because they lack clinicians to staff the units 24 hours/7 days a week. They respond not only to their own patients, but consult to drug and alcohol units, staff acute psychiatric units,consult on medical wards, see POW patients and provide community and professional education while trying to plug the holes in their units.

Meanwhile the VA Central Office has faced multiple and increasing demands on its scarce resources. In the face of waiting lists or nonavailable treatment, numerous veterans filed claims for disability. The agency seems to be forced to pay whether it had PTSD units or not. Consistent with recent advances the hospitals have been encouraged to decide their own priorities. Provision of PTSD services was based on the perception of local needs.

PTSD remained one of a number of competing needs. Faced with no clear mandate from Congress in the form of allocated funds, and no common consensus of internal opinion, PTSD priorities have remained one of several pressing but competing issues. Research and evaluation dollars in the system have been equally tied up. Used primarily for recruitment and retention of basic medical and research staff, few dollars in that pool have beenavailable to assess the needs, evaluate the services or document the outcomes. PTSD has remained a new competing and upstart stepchild. Review boards have been neither particularly conversant not competent in PTSD research.

In this atmosphere, Vet Centers, PTSD researchers, and PTSD treatment units find themselves vying for the same small funds on the edge of the already beleagured medical system.

For those of us with a long concern about PTSD and veterans, the choices have been hard. Some of us have stayed outside and attacked the agency in the past for not doing enough. But we also have not adequately supported the efforts made while we decried them as inadequate. It took years for us to conduct the research that would begin to document the need. We were slow to recognize the demands on the system and make our case for priority of our concerns. We now have begun to join that sytem and begin to make our case.

But if the agency in to respond, and if we are to be given the space to create the models, for integrating the Vet Centers, for documenting our effctiveness, for structuring our programs for success as well as cost effectiveness, we need support. Not just in words, for they mean less in a time of budget deficits. We need a message from Congress, not just in words directing an already beleagured agency to multiple its loaves and fishes;we need a message in concrete terms. We and the Agency will know that PTSD treatment to complement the Readjustment Counseling Service is a priority and important when modest supplemental allocations are designated with this legislation and appropriated for PTSD treatment programs.

The seeds are planted. They are hardy seeds and have and will survive with little nourishment. Dreams, plans and programs such as those attached are ready to be implemented. PTSD experts are eager to sweat and toil to make these PTSD centers grow. If the resources accompany the words, these programs will provide the backbone of the treatment, research and education system in PTSD this legislation intends. If not, the struggle to hunker down, face the waiting lists, eke out the resources will continue. But the Committe should be aware that the men and women of the PTSD units and the Vet Center program value their service and committment by the degree to which they continue to serve the needs of the men and women who served under them, next to them or for them in Vietnam. As veterans our task is not done until the continuing needs are addressed. And we do dare to think and say with relection and sober thought, that the legacy of service related problems deserves priority. If hard choices must be made, we believe that physical injury and mental trauma from war experience deserve consideration over dental care and coronary units.What the civilian sector cannot provide, and what is directly service related, should be the province of the agency which serves those who have borne the battle.

1. INTRODUCTION

This proposal describes the organization and resources required for a comprehensive center for the study and treatment of Post Traumatic Stress Disorder (PTSD). Sincre relatively little is known about the diagnosis and treatment of PTSD this Center is designed to advance knowledge about of PTSD as well as serve as an educational site. This proposal recognizes that PTSD is not confined to Vietnam Veterans alone; female veterans, combat veterans of other eras and in particular POWs are also affected. It also acknowledges that the impact of PTSD is not confined to specialized PTSD units but affects the entire Medical Center and the community at large. Innovative approaches included in this proposal are (1) the integration of a variety of effective therapeutic strategies, (2) greater involvement of the vet centers with the medical center, and (3) provision for the development of training, evaluation and research for the Medical Center and Region.

2. GOALS AND OBJECTIVES

To develop a comprehensive regional center for the study and treatment of post traumatic stress.

To study the relative efficacy of existing and innovative treatments.

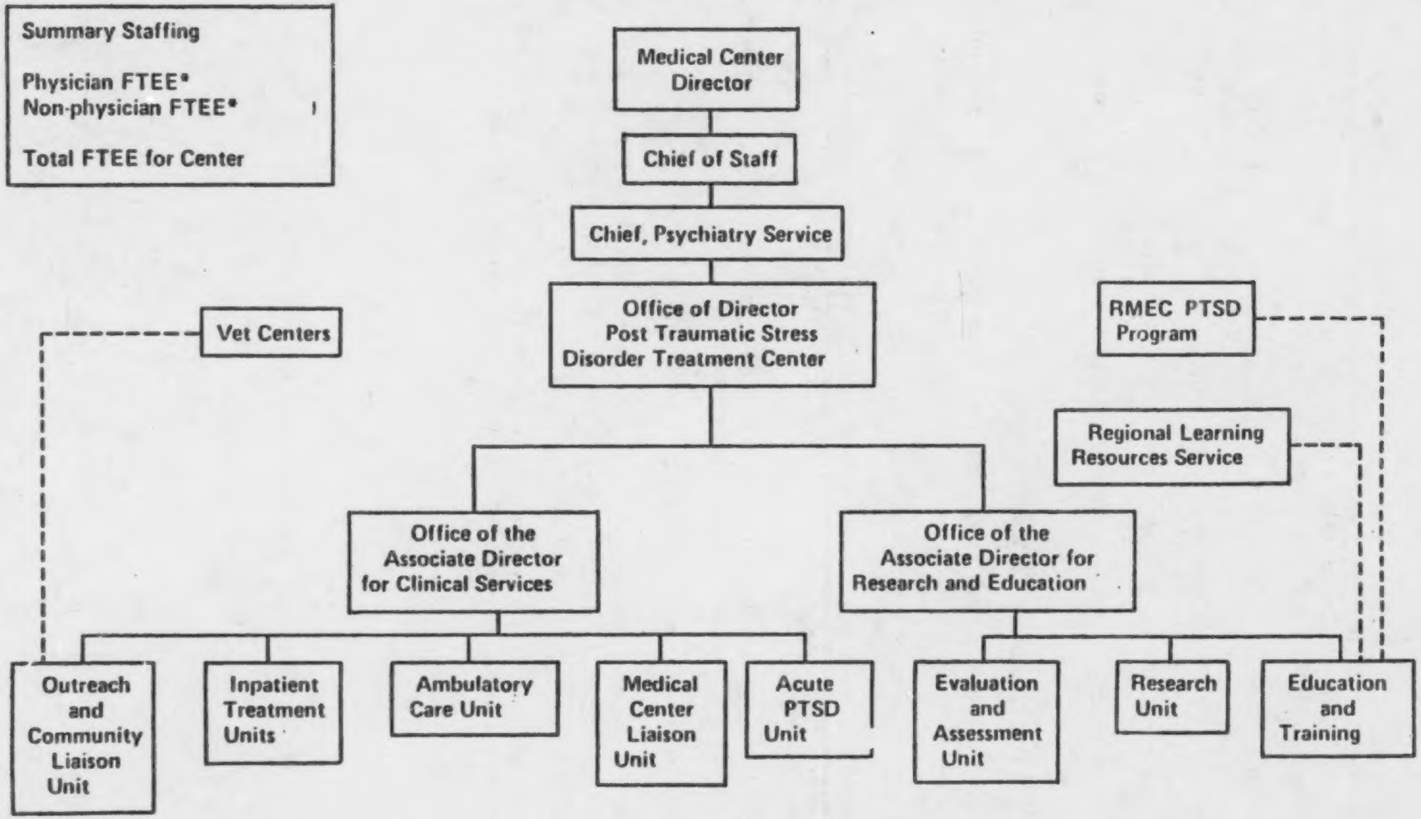
To develop a working partnership with existing community resources, particulary the Vet Centers, to provide additional vocational, social and readjustment services to patients with PTSD.

To provide both consultation and treatment for the Medical Center and Region on assessment and treatment of stress disorders.

To facilitate research in acute and chronic reactions to stress.

To develop an educational program in the assessment and treatment of PTSD as a resource for the training of staff thoughout the Department of Medicine and Surgery.

To develop an ambulatory care program (1) to provide continuing care and (2) for patients who need treatment but who do not require hospitalization.


Summary Staffing
Physician FTEE*
Non-physician FTEE*
Total FTEE for Center
Medical Center Director
Chief of Staff
Chief, Psychiatry Service
Office of Director Post Traumatic Stress Disorder Treatment Center
Vet Centers
RMEC PTSD Program
Regional Learning Resources Service
Office of the Associate Director for Clinical Services
Office of the Associate Director for Research and Education
Outreach and Community Liaison Unit
Inpatient Treatment Units
Ambulatory Care Unit
Medical Center Liaison Unit
Acute PTSD Unit
Evaluation and Assessment Unit
Research Unit
Education and Training

3. ORGANIZATION OF THE CENTER

The overall orzanization of the Center is presented graphically in the enclosed organization charts. Summary narrative descriptions of each unit and program within the center follow below.

OFFICE OF ASSOCIATE DIRECTOR FOR CLINICAL SERVICES.

Outreach and Community Liaison Unit:
The personnel assigned to the unit will coordinate existing community resources, assist in the development of complementary veteran vocational and readjustment services, and provide direct crisis intervention services to veterans in the community in consultation with community and public safety agencies. The unit will provide a direct link with local Vet Centers and provide liaison with other Vet Centers throughout the region. Staff in this unit will serve as an initial contact point in order to facilitate entry into the program and develop follow up options for veterans returning to home communities throughout the region.

Inpatient Treatment Units:
(a) Vietnam Veteran Treatment Unit
This inpatient unit is a structured treatment program for the assessment, stabilization and initial resolution of stress disorders as well as an orientation to community reentry. This unit contains a concentration of readjustment counselors since it will be a 24 hour/ 7 day a week therapeutic program - to insure clinical staff on hand whenever needed and to obviate difficulties encountered by other inpatient units. This unit also provides beds for immediate crisis readmissions.

Target population: Vietnam veterans with PTSD problems without major psychiatric disorder or substance abuse problems which would impair ability to benefit from the structured residential treatment program.

(b) Specialized PTSD Treatment Unit
This inpatient treatment unit will consist of a structured treatment program which utilizes treatment protocols targeted at specific symptom clusters (for example, intensive sleep distrubances, intrusive thoughts and flashbacks, impulse control problems).
This unit will provide important data about the variability of PTSD inpatients with different backgrounds and with different stressors. Individualized treatment and the development of specialized treatment protocols will be a primary goal of this program.

Target population: Veterans of any era who meet the critiera for any ongoing specialized treatment protocol. WW II, Korean veterans, POWs from several eras as well as male and female Vietnam veterans will be sought for this unit.

Ambulatory Care Unit:
This unit provides followup for patients discharged from the inpatient units who live within commuting distance of the medical center or satellite units at the local vet centers and the Canton outpatient clinic. The unit will also provide a cost efficient treatment option for patients whose clinical condition does not necessitate inpatient care. The objective of direct admissions to ambulatory care

is to maintain optimal function and community integration and ensure community stability while providing appropriate treatment for serious PTSD. This unit will offer outpatient treatment of graduated intensities ranging from 5 days a week to once a week. Thus, the level of services provided to a patient will be determined by the patient's clinical needs. Ambulatory services will include individual, group, marital and somatic therapies in combination with individually tailored vocational and readjustment services. Additional Vet Center space and augmented clinical and clerical Vet Center staff will be required to accomodate the increased patient load.

Target population: PTSD patients whose difficulties are too serious for Vet Center care but whose community and functional stability permit care on an outpatient basis.

Medical Center Liaison Unit:
There are numerous patients whose clinical condition necessitates treatment on another clinical service in the Medical Center. This unit will provide ongoing consultation and liaison services to insure appropriate treatment of PTSD problems on medical units as well as to insure the continuity of care among services.

(a) Psychiatry/PTSD Liaison Program
Professional staff with dual expertise in PTSD and acute psychiatry will provide consultation and limited treatment services to psychiatric treatment personnel on the assessment and treatment of patients with PTSD superimposed on a major psychiatric disorder who because of the severity of the other disorder cannot presently be treated with the PTSD Center. They will also screen patients on psychiatric units for potential admission to the PTSD center.

Target Populations: Patients with other psychiatric diagnoses (e.g. schizophrenia or major affective disorder) for whom other programs within the PTSD center are not presently appropriate but who have contributing PTSD-based problems. Veterans of any era would be served.

(b) Substance Abuse - PTSD Liaison Program
Professional staff with dual expertise in PTSD and substance abuse will provide consultation and limited treatment services to drug and alcohol treatment units. This program will train staff, provide assessment and screening and serve as consultants in the treatment and case management of patients. While assisting in assessment and treatment on the substance abuse units, the liaison staff would facilitate the transition to a PTSD unit when appropriate.

Target population: Patients with a clear PTSD diagnosis whose substance abuse problems currently preclude admission to a PTSD center unit.

(c) Medical-PTSD Liaison Program:
Professional staff with dual expertise in medical-surgical consultation and PTSD will provide consultation and limited treatment services to medical and surgical wards. By consulting and providing secondary case management and treatment services, screening and assessment for patients with medical problems who present PTSD symptoms, the program will ensure that all services in the hospital have adequate access to expertise in the management of PTSD-related problems.

Target Population: Patients with a variety of medical problems being treated on medical-surgical wards who manifest PTSD related problems.

Acute PTSD Unit:
Professional staff on this unit will provide post traumatic stress treatment to a veteran and civilian population with acute stress related problems. Understanding of acute post traumatic stress reactions is central to understanding the stress recovery process in general. If the VA is to assume a leadership role in the PTSD area where veterans make up the largest population, this capacity is essential. Services will be largely ambulatory in this unit. If inpatient treatment is required, a contract to share resources with University Hosptials and Cleveland Metropolitan General Hospital would allow inpatient treatment of civilian PTSD patients at the VAMC in return for either comparable inpatient services rendered by non VA hospitals for veterans or other needed hospital services (e.g. NMR scans for veterans). Research and training in the acute stress process will take place in the University and Cleveland Metropolitan General Hospitals. The transformation from victim to survivor is the goal of this unit.

Target Population: Veteran and civilian victims of accidents, fires, assault, childhood parental loss, rape, incest, terminal illness and other significant recent stressors will be treated.

OFFICE OF ASSOCIATE DIRECTOR FOR RESEARCH, EVALUATION AND TRAINING

The personnel requirements for the two research and evaluation components are contingent on the use of automated data entry and data processing equipment (microcomputers and access to facility ADP equipment).

Evaluation and Assessment Unit:
This unit will conduct a thorough initial assessment on each patient entering any unit of the PTSD Center. This assessment will include extensive demographic information, family, military, vocational, social, treatment and medical histories as well as a standardized comprehensive PTSD and psychological testing battery designed for the unit. Professional staff of the unit will then recommend an individualized treatment plan and assignment to the appropriate treatment component. Data collection staff will conduct periodic continuing data collection on symptoms, functioning, resource utilization, comparative treatment efficacy and clinical course. The research and analysis staff will provide periodic and timely reports, and publications documenting and evaluating the results of these data. This unit could serve as a center for collection of evaluation, assessment and outcome data from other PTSD programs.

Research Unit:
This basic research unit will provide core seed staff to stimulate basic research in acute and chronic stress disorders, their natural history, etiology, and physiological and social features as well as innovative and experimental treatments. The unit will also serve as a focus and support for cooperative studies in basic and clinical PTSD research.

Education and Training Unit:
The staff of this education and training unit will develop and coordinate an ongoing continuing education and training program for the Center staff.

(a) PTSD Clinical Training Program: The staff of this program will develop and coordinate a fellowship and mini-residency program for professional training in PTSD in conjunction with other existing PTSD programs and the Readjustment

Counseling Service.

(b) Training and Education Program: The program serves a liaison with the RMEC based PTSD Training and Education Program for PTSD. The RMEC PTSD training and education program will develop and implement, with professional staff and experts from throughout the VA and civilian sectors a program of consultation, education and training for all clinical and administrative services in treatment, research and program development for PTSD. Existing PTSD treatment programs and the Readjustment Counseling Service and the Vet Centers and their personnel will provide additional expertise for this effort.

(c) Mid Atlantic RMEC Education and Training Program: This program will plan, develop, implement and evaluate PTSD educational services for the VA nationally. Education and Training programs consist of the following major components: assessment and collaboration of regional centers; assessment and collaboration of existing inpatient PTSD programs; short and long term mini residencies; PTSD conferences; development of prototype for inservice unit level training.

Appendix B

Duke University
DURHAM
NORTH CAROLINA

DEPARTMENT OF PSYCHOLOGY

POSTAL CODE 27706
TELEPHONE 919—684—4121

To: Phillip White,M.D. , Director, VAMC Cleveland
From: John Russell Smith
Date 24 February 1984
Subject: CENTER FOR TRAUMA RECOVERY

The timing is right for comprehensive treatment programs in Post Traumatic Stress. Such programs could place the VA in world leadership in this field Post Traumatic Stress is the single medical issue outside physical rehabilitation or prosthetics which is clearly the domain of the VA. The problem is directly service related. Veterans form the largest population of those with PTSD. Such a CENTER FOR TRAUMA RECOVERY could accomplish the following goals:

1. Create the 1st comprehensive PTSD treatment program.
   Integrate targeted inpatient/outpatient services
   Consolidate related treatment services
   Shorten inpatient time
   Enhance treatment success rate
2. Integrate all recent treatment advances.
   Physiological,behavioral,pharmacological innovations by Horowitz, Keane at Jackson, Kolb at Albany, Penk at Dallas could be incorporated.
3. Integrate Vet Centers and medical centers.
   Provide 1st model for RCS and VAMC integration.
4. Create 1st program for all PTSD veterans.
   Women, Vietnam, Korean, WW II veterans included.
5. Provide 1st hard research data on treatment.
   Differential assessment, treatment outcome and limits.
   Data to settle PTSD or no questions,multiple diagnoses.

6. Launch VA into general PTSD leadership. Integrate VA, Case Western, county hospitals in programs for civilians, police, firemen, rescue workers, medical trauma victims, rape, bereavement, disaster, assault and burn victims. Associations already in place.
7. Provide data for discrimination of minority of compensable PTSD cases from majority of recoverable ones.
8. Create training and residency programs in PTSD. Coordinated with Case Western and RMEC
9. Reverse recent adverse VA publicity on PTSD. Structure, design and staffing obviate problems of other units.

UNIQUE ASPECTS OF THE CENTER FOR TRAUMA RECOVERY

A. Top Staff - best clinicians and researchers in and out of VA on board or actively considering affiliation.

B. Full Hospital Support- Cleveland VAMC unique in degree of commitment and support.

C. Vet Center and Hospital Integration- coordination mechanisms already established. Exist nowwhere else in this form.

D. Full Time Coverage- 24 hr/7 day coverage by clinicians places resources on hand whenever needed. Crisis service. Immediate rehospitalization eased. Close coordination with community emergency services and public safety.

E. Client Responsibility- Prime emphasis on client responsibility for actions and consequences. Staff and client focus on enhancing control over alcohol,drugs, weapons,and destructive behavior in multiple daily examinations of acts.

F. Broad Clientele. - Women, Vietnam, Korea, WWII clients

G. Extensive Community Involvement- Client involved in supervised commuity enhancement projects. Extensive veteran organization, community agency and successful peer role model support network developed for maximum impact.

H. General Post Trauma Program- Case Western and affiliated hospital program for other survivors.

I. Built in assessment and outcome research.

J. In house residency and training program with RMEC and Case Western

K. International Advisory Board- leading world experts on PTSD have agreed to ongoing consultation to program.

L. Buddy system- program and vet center graduates encouraged and expected after screening and training to serve as 24 hour on call buddies for crisis, support and accompaniment on difficut matters.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION

before the

COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
UNITED STATES HOUSE OF REPRESENTATIVES

on

VIETNAM VETERAN "COMBAT UNITS", PTSD, READJUSTMENT COUNSELING PROGRAM AND VET CENTER PROGRAM

March 29, 1984

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
MARCH 29, 1984

Mr. Chairman and Members of the Subcommittee:

The American Legion is appreciative of the oppportunity to appear before the Subcommittee today to address H.R. 4833; a measure that would provide comprehensive treatment services to veterans who served in-country Vietnam and are suffering post-traumatic stress disorder; and to present our views on other issues related to PTSD and the Vet Center program. These issues are extremely important to a large number of Vietnam veterans and their families, and have long been a concern of The American Legion.

H. R. 4833

The first provision of this measure would amend subchapter II, Chapter 17 of title 38, United States Code, by establishing a new section that provides that the Administrator may furnish treatment services to any veteran who is eligible for care or services under section 610 or 612 of the title; who served in the Vietnam theater of operations during the Vietnam Era; and is determined by the Administrator to be suffering from post-traumatic stress disorder. The services include hospital care, medical services, outpatient services, counseling to family members and other persons in primary social relationships with a veteran, rehabilitative services, vocational counseling, home health services and such other services found necessary for the treatment of the veteran. Such services would be furnished without regard to any limitation under any other provision of the title on the furnishing of such services by the Administrator.

According to the bill, services would be provided only through treatment units established for the treatment of post-traumatic stress disorder by VA in existing Veterans Administration medical facilities - not to be established at more than 15 medical facilities.

A significant and most important aspect of this provision would require the Administrator to identify the resources allocated to such treatment units in material submitted with the President's budget for each fiscal year during which the units are proposed to be in operation under the budget.

Mr. Chairman, The American Legion strongly supports the intent of this portion of H.R. 4833. It would legitimize, by funding, the 10 existing PTSD treatment units and provide for the establishment of additional units. As we understand the language contained in the measure, it would provide treatment to Vietnam veterans with post-traumatic stress disorder, regardless of whether or not the veteran's claim for service connection of PTSD has been approved. This is important to the Legion for reasons that will be discussed in greater detail later in this statement.

An extremely important part of the proposal is that which would provide that resources be allocated for the treatment units in the Veterans Administration budget. Currently, the PTSD units, as well as most other special programs such as examinations and treatment provided veterans exposed to Agent Orange and Radiation, are not separately funded. A frequent complaint registered with Legion Field Representatives during site visits to VA medical centers is that the responsibility for implementing such programs is placed upon the facilities, but that no additional funding is provided with which to operate or staff the programs.

The American Legion does have one valid question regarding the intent of this legislation. If the establishment of PTSD treatment units is limited to no more than 15 VA medical centers, what is to be done in the case of veterans with severe PTSD, requiring inpatient treatment, when these veterans reside in the catchment area of a medical center where a treatment unit is not available?

H.R. 4833 further states that in addition to the provision of treatment services to veterans, such PTSD treatment units shall sponsor efforts to further the education of health-care professionals, including those employed outside the Government, regarding the causes, diagnosis, and treatment of post-traumatic stress disorder. It is also provided that when allocating funds for research relating to post-traumatic stress disorder, the Administrator shall give priority to medical facilities at which PTSD treatment units are located in order that research may, when feasible and otherwise appropriate, be carried out at the treatment units. And the Administrator would be required to compile and publish on a regular basis, the results of research that has been conducted regarding the causes, diagnosis, and treatment of PTSD, and promote the exchange of information concerning the disorder among health care professionals.

Mr. Chairman, The American Legion pointed out during this Subcommittee's hearing of March 24, 1983 that one very disturbing conclusion drawn from the site visit reports prepared by our Field Representatives, and from complaints lodged by American Legion Service Officers is that many VA physicians have differences of opinion regarding post-traumatic stress disorder, including the diagnostic criteria, and the credibility or even the existence of a PTSD diagnosis. It was also reported that some VA physicians discount any mention of Vietnam service or combat during an evaluation, and others do not elicit any military background at all during a PTSD examination.

Unfortunately, we have seen little, if any, improvement over the past year. Therefore, the Legion feels there is a great need for research and an extensive education of VA health-care professionals regarding the causes, diagnosis and treatment of post-traumatic stress disorder.

Mr. Chairman, in response to your request during the aforementioned March 24, 1983 Subcommittee hearing, we furnished a summary of The American Legion's findings regarding inconsistencies and other problems in the way post-traumatic stress disorder is diagnosed and treated within the VA medical care system, and in the manner in which PTSD claims are being evaluated by VA regional offices. The information was provided in a letter under date of March 30, 1983.

It is apparent to us that a concern expressed in our statement a year ago has proven to hold true - that we have only seen the "tip of the iceberg" in comparing the number of Vietnam veterans who have sought counseling or treatment for PTSD with the total number who have actually incurred at least some symptoms of the condition. A majority of Vietnam veterans seemingly made a successful transition from the hostilities of combat, back into civilian society. It was discovered early on that others were undergoing serious readjustment difficulties brought on by post-traumatic stress disorder and other physical and psychological problems. It has only been recently found that a significant number of the Vietnam veterans who had appeared to have made a rapid readjustment are now manifesting symptoms of PTSD in varying degrees. Examples are difficulty maintaining employment as they cannot remain on any one job for any length of time; problems in sustaining interpersonal relationships, including intimacy problems, because of an inability to trust or get close to a spouse, partner or friends; sleep disturbance, memory impairment, negative self-image, and other delayed reactions attributable at least in part to their military experience.

Experts in the diagnosis and treatment of PTSD estimate that between 30 and 60 percent of all combat veterans of Vietnam, plus additional non-combat veterans such as a number of hospital and graves registration personnel are suffering at least some symptoms of the disorder. Our feeling is that the percentage of combat veterans affected is probably closer to the higher end of the scale based upon the pre-test of the Columbia University and American Legion Study of Vietnam Era Veterans. The pre-test findings on the actual incidence of post-traumatic stress disorder led to an increase in the number of questions relating to PTSD on the questionnaire that is being used in the full study.

The problems relating to the manner in which the Veterans Administration is handling the issue of post-traumatic stress disorder are extremely disconcerting to The American Legion, with respect to the inconsistencies in the diagnosis and provision of treatment at VA medical centers, and the adjudication of claims in the regional offices. We have continued, since early 1982, to track these problems, and the following are but a few examples, extracted from reports by our Field Representatives subsequent to our letter of March 30, 1983, reflecting how PTSD is handled at various facilities, the problems that have been identified by our staff, and in some instances by VA personnel.

VAMC Boise, ID, April 14, 1983 - There were several concerns expressed about post-traumatic stress disorder at this VAMC. It was reported by the Chief of Psychiatry that the Boise VA Regional Office is not treating Compensation and Pension examinations fairly. It was reported that within the Mental Hygiene Clinic, 20 to 25 percent of all Vietnam veterans seen are diagnosed as having PTSD symptoms. Oftentimes veterans have multiple problems of which PTSD is only one. The Chief stated that veterans are not being given any benefit of the doubt in their PTSD claims. It was reported that of all the claims for service connection of PTSD sent to the regional office only one or two at most were adjudicated in favor of the veteran.

VAMC Allen Park, MI, May 11, 1983 - The Chief of the Psychiatric Service said that a psychiatrist was hired in 1970 specifically to handle groups for Vietnam veterans. A small unit was established for a short time, but due to the volatile patients and lack of adequate space and staff, it was discontinued. They are now housed with general psychiatric patients. Counseling is also provided at the Vet Centers and through the Fee Provider program. The greatest problem has been with the adjudication of claims. The Chief of Psychiatry said that nearly 99 percent of the claims in the past have been disallowed. This has since been reduced to about 50 percent. She stated that there did not seem to be a happy medium. If they did not go into a lot of detail, the adjudicators said that there was not enough evidence to support a claim. If they did go into detail, they were told that they sounded like advocates for the veterans. There have been some veterans who have had their claims denied more than once. There are plans to establish a 3-4 member panel to confirm a diagnosis of PTSD prior to its going to adjudication.

VET CENTER Detroit, MI, May 11, 1983 - The treatment of PTSD is fragmented. Some is done at the Vet Center, some at the hospital and some through the Fee Provider program. The greatest concern is the adjudication of claims. In the past over 90 percent have been denied.

VAMC Canandaigua, NY, May 10, 1983 - Treatment for PTSD was initiated in 1979. Criteria for diagnosis was reported to be the given DM&S criteria, essentially that of DSM-III. Development of a formal program has been debated, but it was determined that the caseload was insufficient, and the staffing resources were not available for a top-notch program. A survey of hospitalized veterans for PTSD at this facility during the past year indicated 18 veterans were discharged with the diagnosis and 17 remain hospitalized. This is a long-term care facility and referred patients, usually, are those that cannot be handled at another facility. Those veterans not requiring hospitalization can be referred to the program at the outpatient clinic in Rochester. It was of interest to note that one of the psychiatrists was using hypnosis/sodium amytal as a treatment modality.

VAMC Fort Meade, SD, June 23, 1983 - The treatment of veterans with PTSD began early in 1982. The evolution of the program has been a bumpy road. The first psychiatrist assigned to the program was oriental and rigid in his treatment process. This brought about much resentment and acting out by patients toward the staff. The Chief of Psychiatry said that the psychiatrist in charge was removed for his own safety. The new psychiatrist turned out to have a much more rigid regime, thus, the problems became worse. This program is not specially funded, therefore the staff, in my opinion, is not adequately trained for the high intensity situations they encounter. Also, their numbers are not adequate due to the low core staffing at the medical center. Turnover of staff leads to less and less consistency of treatment.

The Team Leader of the Vet Center in Rapid City (about 30 miles away) is aware of the problems regarding this treatment program, but says he tries to maintain an open mind regarding the complaints. He said he has provided some training to the ward staff, but they have since turned over and another training session is needed. The PTSD patients are housed on the same unit as general psychiatric patients. The Team Leader said he is working closely with Psychology and Psychiatry Services to stabilize the situation, and has been receiving good support. He also agrees that the unit staffing is low, but that increased numbers is not the only answer. He said that the PTSD veteran is suspicious of the VA and if staff is increased to just provide control of outbursts, it will make the situation worse. Proper training is also needed by the staff to handle the situations that arise without resorting to goon squad activities.

VAMC Erie, PA. June 29, 1983 - The Chief of Psychiatry reported that VA regional office claim evaluations are very strict with respect to the adjudication of PTSD claims. In several instances the Chief related that cases that he evaluated as having PTSD were turned down by the VA regional office. He believed that criteria used by regional office personnel was, in some cases, too restricting.

VAMC Miami, FL, March 21, 1984 - Through conversations with the Chief of Psychology and the Veterans Outreach Center Team Leader, it was determined that during the past year the number of veterans at the Vet Center and VAMC Miami with PTSD symptoms has reportedly increased. It was indicated that if VAMC Miami had sufficient space and resources, a Stress Disorder Treatment Unit of 12-15 beds could be established. The number of veterans who could stand to gain from an SDTU was reported as large enough to maintain an 80 percent occupancy rate. With a lack of resources and space, this idea most likely will not materialize.

The closest SDTU to Miami is VAMC Bay Pines which operates a 20 bed Stress Disorder Treatment Unit. VAMC Miami is rarely successful referring veterans to Bay Pines, as the SDTU beds are generally full. Several incidences in recent months point out the need for more SDTU beds in South Florida. Several Vietnam veterans have become violent while inpatients on the VAMC's psychiatry unit, or on outpatient status. Since VAMC Miami operates an acute, short-term stay psychiatry service, the hospital cannot deal with potentially violent patients. These patients end up being admitted to state psychiatric facilities. At the time of this visit, four former hospital patients (all Vietnam veterans) were hospitalized in state institutions. In my opinion this is a real outrage. Florida's VAMCs do not have adequate long-term psychiatric facilities. It is known that veterans from within Florida have had to be transferred to VAMCs in other states for treatment. Now, the VA facilities in these other states cannot accommodate the Florida veterans, so the violent veteran ends up in a state institution - rather bizarre.

The Vet Center and Miami VAMC Psychology Service have begun an inhospital program to provide individual and group therapy while hospitalized. A Vet Center counselor conducts three groups per week at the VAMC. It was reported that 40-50 percent of all psychiatry admissions are Vietnam veterans. The Psychology Service Chief began the co-facilitated counseling program to ease the problems of these Vietnam veterans. The specific problems of deserving Vietnam veterans - PTSD and other readjustment problems - are not being met in an altogether satisfactory manner. Support for PTSD ratings from the adjudication section of the St. Petersburg Regional Office was reported as improving but not exceptional.

Mr. Chairman, with your permission, we would like to summarize the problems that we perceive in the Veterans Administration's handling of post-traumatic stress disorder. While we realize that the adjudication of PTSD claims by VA regional office rating boards is not under consideration during this hearing, there is a relationship between the disability evaluation examinations and the rating of these cases, and it must be said we are finding problems with respect to this relationship.

TREATMENT AND DIAGNOSIS OF PTSD

There is no consistency in the treatment of PTSD on an in-patient basis throughout the VA medical care system. We have provided some examples of how it is being treated at different medical centers, and some of the problems that are being experienced. It appears from what we have been able to gather that individual paychiatrists oftentimes incorporate their personal methods of treatment, regardless of the proven effectiveness. To The American Legion this demonstrates a need for immediate research on the treatment of post-traumatic stress disorder.

In the interim, a temporary solution might possibly be formulated by asking the clinicians most knowledgeable in this area to write a program - or guidelines - on the best proven methods of treating PTSD. This would at least provide consistency throughout the system.

As previously mentioned, many VA physicians seem to have differences of opinion concerning post-traumatic stress disorder. This includes the diagnostic criteria, the credibility of a PTSD diagnosis and, in some cases, even the existence of PTSD as a diagnosable condition. Judging from the quality of some examinations for rating purposes The American Legion feels that there is a continuing need for the education of VA psychiatrists on evaluating and diagnosing PTSD.

POST-TRAUMATIC STRESS DISORDER CLAIMS

The American Legion has found that there are a variety of problems associated with the adjudication of PTSD claims. Some relate to a lack of documentation of the "stressors" of duty in Vietnam. There is the problem of psychiatric examinations that are less than adequate and the subsequent negative impact on ratings based on such examinations. And there are problems resulting from the attitudes of some VA personnel.

As for documentation of information relating to an individual' experiences in Vietnam, the veteran, upon application for service connection, may make statements concerning incidents or experiences occurring many years past. Generally, it is difficult to provide any type of corroborating documentation with the exception of a combat award such as a Purple Heart, Combat Infantry Badge, Combat Medical Badge, or an award for valor. A rating examination must be based on a history related by the veteran which may or may not be voluntarily provided. This puts such a claim at a definite disadvantage, since some examining physicians are not sufficiently familiar with military activities in Vietnam to elicit all of the necessary information, particularly, in the case of veterans who are reluctant to discuss their combat experiences. Thus, the resulting diagnosis, in many instances, does not adequately reflect the onset or evolution of the veteran's current condition.

In this regard, the Veterans Administration has an obligation and responsibility to undertake development and confirmation of certain information relating to the individual's military service. VA, however, has not fully taken the initiative in this situation. The American Legion is pleased that the Army Agent Orange Task Force has agreed to take responsibility for conducting research of military records to document PTSD claims in response to requests for information from veterans, accredited representatives or VA. We have found the AAOTF to be responsive and cooperative. Unfortunately, their staffing is limited and the research is very time consuming. However, without the information that the AAOTF can often provide, many claims are denied due to a "lack of a demonstrated stressor in Vietnam".

With respect to inadequate rating examinations, the Legion has all too often been confronted with diagnoses of personality disorder or anti-social personality, with no finding of PTSD. Many times we have found that no military history was elicited from the veteran during the examination and although the veteran exhibits symptoms such as recurrent dreams about being killed in Vietnam, survival guilt, startle response, limited social or interpersonal relationships, etc., etc., the examining physician arbitrarily states that there is no evidence to support a diagnosis of PTSD.

It is also apparent that some examinations are conducted by individuals who are unfamiliar with the information needed to rate the case. Certain facts may not be included in the examination report, either out of a lack of understanding of the adjudication process or a conscious decision that not everything related by the veteran is important to his case. Unless further training, communication and coordination between the Department of Veterans Benefits and the Department of Medicine and Surgery is undertaken, many claims will continue to receive incomplete examinations resulting in premature denials.

The American Legion has found the adjudication of PTSD claims to be extraordinarily stringent in a significant number of cases. This is also substantiated by the foregoing comments we are receiving from psychiatrists and psychologists at some VA medical centers.

While The American Legion is aware that problems do not exist in every medical center or regional office, it is disturbing to know that any Vietnam veteran is not receiving fair and equitable treatment by the Veterans Administration. And the Legion will not tolerate employees of the Veterans Administration who unilaterally decide that PTSD is not a valid diagnosis. That issue has been settled and appropriate directives have been issued. Any VA employees who will not or cannot accept it should not be in VA service.

REALLOCATION OF SURPLUS READJUSTMENT COUNSELING CONTRACT FUNDS

Mr. Chairman, we have also been invited to comment on a portion of the Committee on Veterans Affairs' report to the Budget Committee on the proposed budget for FY 1985 dealing with the reallocation of surplus readjustment counseling contract funds.

Language contained in the report states that in the last three fiscal years, the Veterans Administration has not been able to obligate most of the funds earmarked for the Vietnam Veterans Readjustment Counseling contract program. And, that in recent testimony before the Committee on Veterans Affairs, the Chief Medical Director stated that the VA has experienced difficulty in locating adequate numbers of qualified private sector organizations which could provide such services by contract. Additionally, according to the report, the Chief Medical Director stated that lack of authorized FTEE ceilings has made it impossible to use these funds to establish and staff additional VA operated Vet Centers. The Committee recommended that 220 additional FTEE be allocated to the Readjustment Counseling program, and that the Chief Medical Director take action to use surplus contract program funds to establish additional Vet Centers.

Mr. Chairman, if the Veterans Affairs Committee is satisfied that the surplus of contracting funds is due to a difficulty in locating qualified contract counselors, The American Legion would certainly not offer any objection to the proposed reallocation of funds, with one proviso - that the funds be used only for staffing of the Readjustment Counseling program and the establishment of additional Vet Centers.

We are aware that the existing Vet Centers are continuing to experience increasing work loads due, in a large part, to new

Vietnam veteran clients seeking assistance. This parallels our earlier discussion on the number of Vietnam veterans who are beginning to manifest or finally realize that they have incurred symptoms of post-traumatic stress disorder, and other readjustment problems. We also know from our Field Service reports and through conversations and correspondence with Vietnam veterans that there are areas of the country where readjustment counseling services are needed, but are not available.

The American Legion continues to find that the Vet Center program is doing well in accomplishing the purpose for which it was established - to provide readjustment counseling and referral services to those veterans who have not satisfactorily completed post-Vietnam recovery and readjustment processes. Because of the success of this program, The American Legion has totally supported and will continue to support the Vet Center program, as mandated by Resolution No. 49, approved by the Delegates to our 1983 National Convention (copy attached), for as long as there is a demonstrated need for these important services.

In conclusion, Mr. Chairman, The American Legion will continue to monitor all activities relating to the handling of post-traumatic stress disorder by both VA medical care facilities and the regional offices. We insist that these Vietnam veterans who continue to bear the burdens of their war service, are to be treated compassionately and objectively in their quest for answers and solutions to their readjustment problems.

Mr. Chairman, that concludes our statement.

ATTACHMENT: Resolution No. 49, 1983 National Convention

SIXTY-FIFTH ANNUAL NATIONAL CONVENTION OF THE AMERICAN LEGION
SEATTLE, WASHINGTON, AUGUST 23, 24, 25, 1983

RESOLUTION: No. 49 (Arizona)

COMMITTEE: Veterans Affairs and Rehabilitation

SUBJECT: Support legislation to extend the Vet Center program thereby providing necessary readjustment counseling for Vietnam veterans

WHEREAS, the Vet Center program, established under PL 96-22, and extended under PL 97-72, is now comprised of 136 Vet Centers and Satellites across the country; and

WHEREAS, there are also approximately 500 facilities providing counseling services under contract to the Veterans Administration; and

WHEREAS, during Fiscal Year 1983 it was estimated that between 60,000 to 80,000 new Vietnam veterans would seek assistance through the Vet Center program; and

WHEREAS, there continues to be demonstrated a significant need for additional research on the readjustment and health of Vietnam veterans; and

WHEREAS, The American Legion through its visits to these Vet Centers has found that the program is performing well and is accomplishing the purpose for which it was established; and

WHEREAS, additional information from the mental health professionals in the country indicate that a much higher number of Vietnam veterans are suffering some symptoms of post-traumatic stress disorder; and

WHEREAS, because of the continuing influx of Vietnam veterans seeking assistance through these Vet Centers, The American Legion believes a further extension of the program is in order; now, therefore, be it

RESOLVED, by The American Legion in National Convention assembled in Seattle, Washington, August 23, 24, 25, 1983, that The American Legion support legislation to provide an extension of the Vet Center program thereby providing necessary readjustment counseling for Vietnam veterans for as long as there is a demonstrated need for such services.

STATEMENT OF
DAVID W. GORMAN
ASSOCIATE DEPUTY NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
MARCH 29, 1984

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 854,000 members of the Disabled American Veterans, I want to thank you and the members of the Subcommittee for allowing us this opportunity to express our views on the Veterans' Readjustment Counseling Program of the Veterans Administration and H.R. 4833--a bill that would provide comprehensive treatment services to veterans who served in the Vietnam theater of operations and are suffering from post-traumatic stress disorder.

H.R. 4833

Introduced on February 9, 1984, by you, Mr. Chairman, H.R. 4833 proposes, through appropriate amendment of Chapter 17, Title 38, United States Code, to create a new section, 620B--Treatment for post-traumatic stress disorder.

Mr. Chairman, if enacted, this measure would authorize the Administrator of Veterans Affairs to furnish treatment services to any veteran who: (1) is eligible for care or services under Section 610 or 612, Title 38, United States Code; (2) served in the Vietnam theater of operations (including the waters adjacent thereto) during the Vietnam Era; and (3) is determined by the Administrator to be suffering from post-traumatic stress disorder.

As envisioned by the bill, the array of services to be provided include hospital care, medical services, outpatient services, counseling to family members and other persons in primary social relationships with a veteran, rehabilitative services, vocational counseling, home health services and such other services as the Administrator finds necessary for the treatment of eligible veterans.

These services may be furnished to eligible veterans, notwithstanding any other provision of Title 38, United States Code and may be provided only through treatment units established for the treatment of post-traumatic stress disorder in existing VA medical facilities, which, under the terms of the bill, shall not total more than 15.

Additionally, Mr. Chairman, these treatment units shall be expected to sponsor efforts to advance the education of health care professionals employed within and outside the government regarding the cause, diagnosis and treatment of post-traumatic stress disorder.

Furthermore, the Administrator shall be required to give priority to VA medical facilities with such a treatment unit when allocating research funds relating to post-traumatic stress disorder, as well as compile and publish the results of such research that has been conducted for the purpose of promoting the exchange of such information among health care professionals.

Under the terms of the measure, the treatment units and services authorized shall commence October 1, 1984 with a proposed termination date of September 30, 1988.

Mr. Chairman, the DAV recognizes the obvious intent of H.R. 4833--to provide Vietnam Era veterans suffering from post-traumatic stress disorder with comprehensive treatment services within the confines of a VA medical facility.

However, as currently constructed, the DAV has two concerns regarding this measure.

First, we note the absence of language requiring that veterans eligible for the comprehensive services outlined be adjudicated by the Veterans Administration as being service-connected for post-traumatic stress disorder.

Admittedly, there may be only a small number of veterans diagnosed as suffering from post-traumatic stress disorder who are not service-connected. However, such cases do exist. To preserve the integrity of this proposal, we suggest that the language defining eligibility criteria be amended to stipulate that such services may only be provided to veterans "suffering from a service-connected post-traumatic stress disorder."

Secondly, Mr. Chairman, we are concerned by the fact that this measure would only apply to veterans of the Vietnam Era who suffer from post-traumatic stress disorder. Veterans of World

War I, World War II, Korea and post-Vietnam Era conflicts and engagements, who do have a bonafide diagnosis of post-traumatic stress disorder, would not be eligible for the services authorized by the enactment of H.R. 4833.

As you know, Mr. Chairman, the DAV has continually expressed its commitment and concern--both in action and words--for assisting those veterans who suffer psychological problems as a result of military service in Vietnam. However, we have been just as staunch in our advocacy for all veterans who suffer service-connected disability(ies) as a result of honorable military service, no matter during which period of war they may have served.

While it may very well prove true that veterans of the Vietnam Era display a greater acute need for the type of services to be provided them in this measure, may it be said that veterans of other periods of military service do not have similar needs? We think not.

Mr. Chairman, we feel it would certainly prove detrimental to the mission and integrity of the Veterans Administration, Department of Medicine and Surgery, if the full array of services embodied in H.R. 4833 were provided to only one class of veterans (Vietnam) suffering from post-traumatic stress disorder and not be provided to similarly situated disabled veterans, including those emotionally disabled from future conflicts in which this nation may be engaged (i.e., Beirut, Grenada).

Accordingly, we suggest that, should H.R. 4833 be favorably reported, its language stipulate that these services may be provided to any veteran suffering with an adjudicated service-connected diagnosis of post-traumatic stress disorder.

VETERANS' READJUSTMENT COUNSELING PROGRAM

As I stated earlier, Mr. Chairman, the DAV has continually expressed its commitment and concern toward assisting Vietnam Era veterans suffering psychological problems associated with their military service in Vietnam. It was the DAV that provided funds for "The Forgotten Warrior Project" study which led, in October, 1978, to the DAV initiating its own Vietnam Veterans Outreach Program. The results of this study had a direct influence on not only our organization's establishment of a specific counseling program for Vietnam Era veterans but, we feel, on the decision of Congress to provide the necessary funds which authorized the Veterans Administration to create "Operation Outreach" and subsequently establish a network of "Vet Centers."

Mr. Chairman, although the VA's Psychological Readjustment Counseling Program had a slow and tremulous beginning, in our view, the VA's system of storefront Vet Centers have generally proven themselves to be successful in assisting Vietnam veterans and their families.

While we believe this program is necessary and will be utilized by veterans of the Vietnam conflict in the future, we continue to strongly support the concept that the VA must plan to integrate these services into the mainstream of traditional and existing VA medical facilities.

Mr. Chairman, you and the members of the Subcommittee are to be commended for recognizing the need to integrate the services now provided by "Vet Centers" directly into VA health care facilities.

I am referring, of course, to the enactment of Public Law 98-160 which required, in part, for the Administrator of Veterans Affairs to take appropriate steps to ensure for the orderly transition by October 1, 1988 of readjustment counseling services from a program now provided primarily through centers located in facilities situated apart from VA health care facilities to a program providing readjustment counseling services primarily through VA health care facilities.

By doing so the VA will not only bring all treatment modalities into existing VA facilities but will be able to phase out, as well, the existing contract services that are being utilized to provide such readjustment counseling services.

Mr. Chairman, this concludes my statement and I wish to again thank you and the members of the Subcommittee for allowing the DAV this opportunity to express our views on these important subjects.

* * *

TESTIMONY

JOSEPH ZOLDAN
NATIONAL COMMANDER
ACCOMPANIED BY
HARRIS B. STONE, PNC
NATIONAL EXECUTIVE DIRECTOR

JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

March 29, 1984

Mr. Chairman and Members of the Subcommittee:

It is an honor for me to appear before you today on behalf of the Jewish War Veterans of the USA.

Mr. Chairman, first, I would like to extend my appreciation and thanks to you and the staff of this Subcommittee for your hard work and continued commitment to maintaining the well-being of our nation's veterans. We support this Subcommittee's recommendation to add $53.7 million for medical care in the VA's FY '85 budget. JWV views this effort as a thoughtful attempt to head off the pending crisis between the health demands of an ever aging veterans population and funding levels recommended by the VA that do not fully meet this demand.

JWV has stated many times that our nation has a clear commitment to maintain and upgrade the quality of VA medical care systems. Our country should never forget those men and women who have served, and in some cases, given the ultimate sacrifice for our country. Today, we are here to defend this principle by speaking out on behalf of Vietnam veterans. Specifically, today, I will share our views on the recent controversy regarding the loss of funds from Vietnam Veterans Outreach Centers.

JWV has consistently supported the concept of using Outreach Centers to treat Vietnam veterans suffering from post-traumatic stress disorder or other readjustment problems. We are most disturbed by recent reports that have accurately stated that a total of $40 million during the last four fiscal years, originally appropriated for the Outreach Centers, has either been diverted to other programs or returned to the Treasury. The Treasury received $16.3 million while the remainder of the $40 million was used for the VA's Nursing Scholarship Program (approximately $8 million), computers and medicines for VA Hospitals.

The problem appears to be an inability to spend funds set-aside for hiring psychotherapists from the private sector. The VA divides the appropriated money into two categories, one for maintaining the Centers and the other part for hiring psychotherapists on a fee for fee contract basis. As documented during a hearing conducted by the House Subcommittee on Intergovernmental Relations and Human Resources, Committee on Government Operations, on January 31, 1984, $33.6 million was set aside by the VA in the last four fiscal years for a fee for fee contract program but only $7 million was actually used for this purpose. The VA claims that Congress set personnel ceilings that did not allow for the expenditure of all the funds appropriated for hiring psychotherapists from the private sector.

A closer look at this problem reveals the inaccuracy of their claim. Congress does set personnel ceilings but only upon recommendation from the VA. Apparently the VA has not been listening to those people directly in charge of these Outreach Centers. Dr. Arthur Arnold, Chief, Psychiatric Service, VA Medical Center, Phoenix, Arizona and Dr. Gary Palmer, Coordinator PTSD program testified on January 31, 1984, that the Outreach Centers were under-staffed and claimed the staff could not handle the demand for counseling veterans without sacrificing the quality of care needed to treat post-traumatic stress disorder.

Furthermore, we believe that the VA has neglected the Vietnam Veteran Outreach Centers. In fact, one VA administrator recommended three times by internal memorandum to limit funds without qualification for the Outreach Centers. This evidence was brought forth in the same Subcommittee hearing held on January 31, 1984.

Congressman Ted Weiss, Chairman of the Subcommittee on Intergovernmental Relations and Human Resources, correctly asked the questions that must be answered in regard to the misuse of funds for this program. Most prominently these questions are: "Why has the VA not prioritized the funding of a national program to research and treat Post Traumatic Stress Disorder?" Second, "Are doctors and officials of the VA fulfilling their obligation to Vietnam veterans, or are there biases which get in the way of doing so?"

JWV of the USA strongly urges this Subcommittee to correct this problem and reaffirm our nation's commitment to Vietnam veterans. We are most encouraged that Congress has extended the life of Outreach Centers until 1987. We believe this current problem can be solved by increasing Congressional oversight by the appropriate Subcommittee and by making funding for this program a line item in the VA budget.

Instead of basing employment ceilings on recommendations from VA administrators, a more accurate ceiling should be calculated by Congress from data submitted by VA personnel who work in these Outreach centers.

Mr. Chairman, thank you for giving us this time to express our views on this important issue.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

PHILIP R. MAYO, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

WITH RESPECT TO

COMPREHENSIVE TREATMENT SERVICES FOR THOSE SUFFERING FROM
POST TRAUMATIC STRESS DISORDER AND THE READJUSTMENT COUNSELING PROGRAM

WASHINGTON, DC MARCH 29, 1984

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to come before you to present, on behalf of our 1.97 million members, our views with respect to H.R. 4833, a measure, introduced by you and co-sponsored by a number of other members of this Subcommittee, to authorize the Administrator of Veterans Affairs to provide comprehensive treatment services to veterans who served in the Vietnam theater of operations and are suffering from post traumatic stress disorder, and on the Veterans Readjustment Counseling Program.

The introduction of this measure as well as a review of the Counseling Program is timely and very much reflect the real concerns of the Subcommittee that veterans receive the best health care available in all areas, and that available resources are best utilized in that regard. We would also like to reiterate our commendation of the Subcommittee as well as the full committeee for their foresight and efforts in securing the passage into law of what is now Public Law 98-160, the "Veterans' Health Care Amend-

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202-543-2239

ments of 1983," a number of the provisions of which have a bearing on the subjects of this meeting today.

Mr. Chairman, the VFW fully supports the concept of the provisions of H.R. 4833. It is certainly not news to anyone present today that the Veterans Administration (VA) currently operates on an informal basis in ten medical facilities throughout the country comprehensive treatment units for post traumatic stress disorder (PTSD), all instigated at the initiative of those individual facilities. The concept of the legislation under review would formalize to some degree the existence of these units. In doing so, we believe the Subcommittee is also recognizing that the VA is in the forefront in the diagnosis, clinical treatment, research and efforts to disseminate information concerning this relatively new separate diagnostic category. We believe it is also recognized by the Subcommittee that these efforts may be enhanced through more informal means of support. We believe such support is necessary in order to meet the study and reporting requirements mandated under the provisions of Public Law 98-160. The bill also provides for new and broader access to treatment for those who suffer from PTSD, but limits treatment to Vietnam theater veterans, through units at a maximum of 15 medical care facilities, and outlines certain treatment services to be provided through those units.

Mr. Chairman, scientific investigations -- whether in the behavioral or more quantitative scientific disciplines -- many times yield varying conclusions from the same facts. This is particularly true, as we see daily in the courts as well as other areas when such expertise is sought, in the practice of the behavioral sciences. It exists insofar as the diagnosis and treatment of PTSD. Consequently, we register our concern regarding the nature and the location of services to be furnished under (b)(1) of H.R. 4833. Our concern is not that the provision of such services as enumerated in the bill is inappropriate, but in making such a prescription, we believe veterans may not receive the best treatment that may be available or necessary for their well-being.

We are concerned as to how veterans and their families who may need such services in "outlying" areas may obtain them. A treatment framework that results in the best utilization of resources in the veterans behalf is what should be established.

Additionally, we wish to express our concern that a limitation on the number of such units is being established. It appears to us that such units should be established at facilities where there is a justifiable need and that the Congress should be asked for the funds for the establishment of those units. Our concern is that the VA not be "painted into a corner" by the imposition of such a restriction in this as well as the previously described instance.

Mr. Chairman, nearly one-quarter of a million veterans have sought services in the 135 existing Vet Centers to date. According to the best information available to us, the new client caseload handled by the 574 FTEE assigned to those units has increased by approximately 6400 per month (as may be seen in comparing the 8600 new cases this February to the 5800 of last February); that it is becoming more apparent that $7 to $8 million of the $11.2 million set aside this year under this program for contract services will be spent on such services, leaving a $3 to $4 million surplus.

It is our view that the services provided under this program are labor intensive and as a result, personnel "burnout" is more likely, and that additional training for Vet Center and contract staff is needed because of that likelihood; that a closer monitoring of the contract services element of the program needs to be undertaken; that it would be beneficial to a number of centers to have additional staff assigned to them. We conclude that these remaining funds in the contract program might be best utilized for additional FTEE to fulfill these needs as well as the establishment of additional needed centers; that is, they be utilized to enhance this program's ability to accomplish its mission. The same goals are evidenced on the part of the Subcommittee in that similar language is found in the Committee's recent report to the Budget Committee.

Mr. Chairman, the same intense nature of treatment necessary for those suffering from PTSD will also (and does) have similar "burnout" effects on those who deal with such in VA hospitals. Proper training for those who move into these positions in VA facilities, as well as the implementation of systems where these personnel are given relief from "burnout" possibilities, is necessary in order for treatment to be effective. We believe the purposeful, stable management of in-hospital treatment is also necessary in learning what will be most beneficial to the VA in assisting Vietnam veterans as well as veterans of earlier, more recent, and future conflicts in finding their way into the "mainstream" of society. The necessary human and physical resources must be committed in order to assure the success of these endeavors.

This concludes my testimony.

TESTIMONY OF DAVID J. PASSAMANECK
Lt. Col., USA, Ret.

NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Before The

SUBCOMMITTEE ON HOSPITALS & HEALTH CARE

HOUSE VETERANS AFFAIRS COMMITTEE

U. S. HOUSE OF REPRESENTATIVES

On
H.R. 4833 - TREATMENT OF POST-TRAUMATIC STRESS DISORDER

9:00 a.m., March 29, 1984

Room 334, Cannon House Office Building

Mr. Chairman, AMVETS is pleased to enthusiastically support H.R. 4833, to provide comprehensive treatment services to veteans who served in Vietnam and are suffering from post-traumatic stress disorder (VA Diagnostic Code 9411).

The diagnosis and treatment of the psychological scars of the Vietnam war have been recognized by the inclusion of Diagnostic Code 9411, post-traumatic stress disorder (PTSD), in the VA Schedule for Rating Disabilities. However, the professional orientation of the health care providers has not sufficiently recognized or understood the realistic horrors of this insidious reminder of those terrible years for so many of our combat veterans. The provision for specialized treatment centers for both therapeutic and educational purposes should serve to improve the understanding and recognition of the condition.

We would suggest that, in order not to unduly restrict the treatment for PTSD, the word "only" in (c)(1) of the proposed new section 620B of Title 38, U.S.C. be deleted, and that (e), the September 30, 1988, cutoff also be deleted. If the program outlives its usefulness at some future date, amendments can be enacted at that time.

I would also like to reiterate our position emphasized by our National Commander before the joint Veterans Committees of the

Senate and House on Wednesday, 28 March when he urged enactment of legislation requiring the opinion of at least two psychiatrists in rating a Vietnam veteran for PTSD. We would advocate inclusion of such a provision in this bill.

That concludes my testimony.

Vietnam Veterans of America, Inc.
329 Eighth Street, N.E.
Washington, D.C. 20002

(202) 546-3700

STATEMENT OF

JOHN F. TERZANO

OF

VIETNAM VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE VETERANS AFFAIRS COMMITTEE

MARCH 29, 1984

Mr. Chairman and members of The Committee, I am honored to be here today to present VVA's views on H.R. 4833, a bill to provide provide comprehensive treatment services for Vietnam Veterans who are suffering from Post-traumatic Stress Disorder and on the Veterans Readajustment Counseling Program.

VVA has a long history of supporting The Vet Center Program and since its inception in 1979 we have continued to support the program. VVA would like to commend the Chairman, the members of The Subcommittee and the full Committee for your work on P.L. 98-160. In addition, VVA appreciates the tremendous work of the Members of the Conference and the Committee staffs who worked out the differences between The House and Senate bills that led to P.L. 98-160. At the time of the conference the "smart" money was on a two year extension for the program, given the 3 year extension by the House and the one year extension by the Senate. But as you have said before Mr. Chairman, instead of substracting the Senate version from the House to come up with a two year extension it was decided to add the two together to arrive at a four year extension. Mr Chairman, The Conference Members should be commended on their very unique negotiation tactics.

Now that the program's future has been assured for the next four years, I believe the Committee needs to focus on expansion of the program. It is the opinion of the majority of researchers that the number of Vietnam veterans who will require readjustment counseling may be upwards of 700,000. Even recognizing that large numbers of veteran clients have already been seen, clearly there are close to a half million veterans who may still require readjustment counseling services. Obviously, we have not even peaked on the number of veterans who could use the services of the Vet Center program. Indeed, Dr. Donald Custis the Chief Medical Director of the VA has himself expressed the need to expand the program-though VVA believes that expansion should have been carried out much sooner. We also believe that the "window of opportunity" for expansion is still open.

VVA recommends a two-tiered expansion.

1. National and regional staffs need to be expanded.

VVA firmly believes that the work of the National Staff and especially the regional staff needs to be augmented with additional staff support. Even though this is not the time to belabor the problem surrounding the contract-for-fees program, VVA feels that the problems would be minimized and the program brought into line if there were individuals in every region whose function is quality control. These individuals should be supported by personnel on the national and regional levels to oversee the administrative and clinical aspects of the contracts-for-fees program to insure the quality of services within the region.

As the program expands, VVA believes that the Regional Coordinators will need support in monitoring the opening of new centers and the expansion of existing centers. Personnel should be allocated to fulfill this administrative function.

Finally VVA is convinced that there needs to be more site visits from those in authority above. This will assist the vet centers personnel not only in their clinical responsibilities but also with their administrative duties.

2. Existing, Vet Centers need to be enhanced and new centers opened.

Given the extrordinary workload of the existing Vet Centers there is a definite need to expand and enhance the program. As was stated earlier it is estimated by many researchers that upwards of 700,000 individuals will have need for Vet Center services. Since the Vet Centers to date have seen approximately 226,000 veterans, it is clear that we have a long way to go.

But, VVA feels that there are steps that can be taken to insure that the quality of services currently provided is high and that new centers open with the requisite personnel and support services. The structure of the teams presently consists, on an average, of four people. Of those four, generally only three are in counseling positions, while one is in an administrative or office management position. Of the three counselors, one is the team leader, whose administrative activities and paperwork consumes approximately twenty five to fifty percent of his or her time. This leaves approximately two and half people doing counseling in each center. It should be noted that fifty percent of the clients seen in the program are seen for longer than two months.

The team leader and his or her counselers need to be doing the work they were hired to do which is to provide readjustment counseling services. They should not be mired in endless streams of paperwork, that is best handled by an administrative individual.

There is also, Mr. Chairman, a need to expand the program significantly. Currently there are 124 vet centers with eleven satellite facilities. The current level of operation clearly will not be able to handle the growing need for the program. It is my understanding that preliminary needs assessments for expansion have been done and I would urge full implementation as soon as possible. It is VVA's belief that the recommendation of the full Committee to reprogram $7.2 million and add an additional 220 FTEs to the program would be adequate to expand and enhance the program. It should be clearly understood that these 220 FTEs should be in addition to the current staffing levels and not individuals transfered from one facility to another.

The Vet Center program has been shown to be extremely cost-effective. The Centers provide excellent services at a lower cost than can be provided by other existing VA programs. Perhaps this committee needs to look into the actual cost of services provided to veterans by the Vet Centers as compared to those other VA programs. We are quite sure that the figures would substantiate this contention.

There are many other areas which must be addressed in order for the program to achieve its true potential. There is a need for a professional back-up for each team. This person would be able to provide assistance to the team with difficult cases, and would be available to the team members themselves for counseling. We must recognize that the employees in this program are in highly stressful jobs. They deal with life and death matters frequently. They work long hours, listening to the pain of others. They have a need for stress management assistance, and such a back-up professional could provide that. It is difficult for a member of the team to function in that capacity since the team members are all involved intricately in the day to day stress of working in the Center.

Our feeling is that the ideal team should consist of a counseling professional such as a psychologist, psychiatrist, MSW, or RN, as well as street level outreach people and a support staff. Presently, about half of the teams have such counseling professionals on staff. We believe that for those teams which do not have such professionals on staff, the need for back up professionals should take first priority.

With respect to the legislation being considered by the Subcommittee, Mr. Chairman, Vietnam Veterans of America would favor enactment of HR 4833 as a preliminary first step. However, given the relative short life span of the Vet Center program, VVA would urge this Committee to reexamine H.R. 4833, as it is presently written, with a view toward substantially increasing the number of available beds and the total number of PTSD units.

The need for in-patient facilities that are designed, equipped, and staffed to professionally address the needs of veterans suffering from Post-traumactic Stress Disorder (PTSD) has long been apparent. But I should add, Mr. Chairman, that H.R. 4833 is very limited and does not meet the current need for these facilities. As you know, the VA Medical system currently has allocated only nine units, with a total of 237 beds, to this much needed service. The VAMC Brecksville (near Cleveland, Ohio) will open a tenth unit on July 1st, 1984 for a total of less then 300 beds systemwide.

H.R. 4833, provides for the creation, at the discretion of the Administrator, of an additional 5 units. The problem with this possible expansion is that it is limited, and it addresses a small percentage of the need currently identified and documented by the Veterans Administration. It would create less then 500 beds systemwide. Approximately 10 percent of the veterans who currently seek assistance from the Vet Centers are determined to be in need of in-patient care. This, conservatively, will amount to more then 10,000 veterans in FY'84 alone who are in need of such services. The average length of stay in such cases is 90 to 120 days. It is clear that the VA would be unable to meet the current need.

VVA notes that H.R. 4833 as currently written would create a situation whereby only one veteran in five who is in need of this care could be serviced. To provide care to those 10,000 veterans needing care this year alone would require 2500 beds. In addition, there is the problem of the backlog of veterans identified as being in need of such care, but who have been unable to obtain this service in the past. It has been estimated that as many as 20,000 veterans are in this category. To provide

Vietnam Veterans of America would further recommend, Mr. Chairman, that a number of these units should be permanent facilities, not subject to the

September 30, 1988 expiration date. There is overwhelming evidence that PTSD is a consequence of life threatening traumatic events. It is a conquence of combat and exposure to death and dying, whether that combat be at Anzio, Vietnam, Grenada, Lebanon, or elsewhere, or the exposure be in graves registration or for medical personnel. There is an apparent need for research and training of professionals to deal with PTSD before young lives are twisted and needlessly scarred by very real wounds that are left untreated. VVA has written to both Administrator Walters and Secretary Weinberger calling for timely assessment and treatment of these unseen but very real wounds that exist in what may be a large number of the young veterans of both Grenada and Lebanon, while treatment would be most effective and efficient. These permanent units would give the VA the capablitity to respond in a clinically effective manner. The existence of 15 permanent units to deal with PTSD would also provide the base for ongoing research into the care and treatment of PTSD as well as serving as training centers for professional certification of PTSD counseling, as providing for in this bill.

In closing, Mr. Chairman, it should be noted, that at the end of World War II 50% of the VA medical facilties had psychiatric units. The VA met head on the psychological problems of the then returning combat veteran, thus minimizing the long term, lasting effects of combat.

Today, less than 12% of VA Medical Centers have these same units. Does not the tremendous service and sacrifices of the Vietnam veteran warrant at a bare minimum the same level of services afforded veterans of previous wars? This Committee has a unique opportunity to move forward with a program that in my opinion is the best program the VA has implemented in years. Let's not "nickel and dime" this program as has been the case in the past with Vietnam veteran programs. Let this Committee send a signal to Vietnam veterans that you care and that you are responsive to their needs.

Thank you.